MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 — 09741 — 57

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

Street No.: First Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rosa Jane Akehurst

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Stephen Arthur Akehurst

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 9, 1879

8. AGE:

Years	Months	Days	If less than one day
68	5	1	hrs. min.

9. Birthplace: Norrisville, Harford Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Thomas Miller

13. Birthplace: Harford Co. Md.

MOTHER

14. Maiden name: Rachel Caroline Eblaugh

15. Birthplace: Maryland

16. Informant: Walter W. Miller

Address: 4427 Sherwood Ave, Balto 12

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13 1947 (month) (day) (year)

Cemetery or crematory: Norrisville Meth. Church

Location: Norrisville, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 11-12 19 47 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 November 19 47, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	Cardiac failure	DURATION
	Arteriosclerosis	
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Walter T. Kuss M. D.

M. D. or other

Address: Cockeysville, Md. Date signed 11-10-47


RECEIVED
NOV 19 1947

STATE OF MARYLAND—CERTIFICATE OF DEATH

09742

93d

1. PLACE OF DEATH

County Balt. Registration Dist. No. 38

Village or City Nr. Towson No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ella Pauline Barham

(a) Residence: No. 6503 Buckwood Rd St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W.	Widowed

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Barham

6. DATE OF BIRTH (month, day, and year) Sept. 9 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	1	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Wm. Pitt

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Mary Litchfield

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Robert Pitt Barham

(Address) 6503 Buckwood Rd

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~

Place London Park Cem. Date 11-4, 1947

19. UNDERTAKER John A. Noonan

(Address) 3000 E. Balto. Street.

20. FILED Nov 3, 1947 H. W. Hadrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Nov. (Month) 1 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July, 1937 to Nov 1, 1947

I last saw h-- alive on Oct 31, 1947; death is said to have occurred on the date stated above, at 2P m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Arterio-Sclerotic Cardio-Vascular disease	1946

Other **Contributory Causes** of importance:

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to externel causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Dete of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles H. Keyser M. D.

(Address) 6701 York Rd. Balto 12 Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09743

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Balto

City or town: Catonsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Home Edmondson Ave & Nunnery La.

How long in hospital or institution? 8 Mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Edmondson Ave & Nunnery Land

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Valerie Belliveau

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Arthur Belliveau

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 23 1862

8. AGE:

Years	Months	Days	If less than one day
85			hrs. min.

9. Birthplace: Boucher Ville Canada

(Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER

12. Name: Charles Cadieux

13. Birthplace: Canada

MOTHER

14. Maiden name: Matilda Roux

15. Birthplace: Canada

16. Informant: Eva B. Maguire

Address: 4001 Groveland Ave

17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 26 1947 (month) (day) (year)

Cemetery or crematory: St. Marys

Location: Burnside Conn

18. Funeral director: Harry E. Kinnacord

Address: 4204 Ridgewood Ave

19. 11-24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1947, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1947, to Nov 23 1947

and that I last saw h alive on Nov 23 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James R Cowell M. D. or other

Address: Catonsville Md Date signed 11/24/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Howell 715 Fredericia

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

09744

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Tufton Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Clarence Alvin Belt

3. (b) Social Security Number 216-07-5716

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sadie Marie Livingston

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 28, ~~1891~~ 1891

8. AGE:	Years	Months	Days	If less than one day
	55	11	18	....hrs. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business Blacksmithing

FATHER

12. Name William H. Welt

13. Birthplace Hampstead, Md.

MOTHER

14. Maiden name Eliza R. Benson

15. Birthplace Baltimore, Md.

16. Informant Chas. H. Welt (Brother)

Address Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12, 1947 (month) (day) (year)

Cemetery or crematory Jessops

Location Sparks, Md.

18. Funeral director Loudon M Brooks

Address Sparks, Md.

19. Nov. 11 1947 Wilmer C. Ensor

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1947 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death Gunshot wound, left chest	11/10/47
Suicide, Sudden	
Due to Neurosis, type not determined	
with nervous breakdown	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death).

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide? Suicide Date of injury 11/10/47

Where did injury occur? Cockeysville (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Shot gun-suicide Injured at work? —

23. SIGNATURE Bolton C. Hudson M.D. DME. M. D. or other

Address Towson 4 Md Date signed 11/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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NOV 14 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09745 43

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Overlea, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Overlea, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 18 Maple Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: OLIVER C. BENHOFF

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bessie B. Benhoff
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 10th, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	13	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Stationery Engineer
11. Industry or business: Southern Hotel
FATHER 12. Name: Henry Benhoff
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: Mr. Edward W. Auld
Address: 5117 Edmondson Ave.
17. burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26th/47 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Baltimore, Md.
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd.
19. Nov. 24 19 47 Mrs. G. L. Rupsmeier Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23rd 19 47 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 46 to Nov. 19 47 and that I last saw h.. l.. M.. alive on Nov. 20 19 47

Immediate cause of death	DURATION
Complete heart block	4½ mo.
Due to Arteriosclerotic C.V.D.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. V. Wood M.D.
M. D. or other
Address: 4718 Harford Rd. Date signed: 11/24/47

RECEIVED
NOV 29 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46b

Reg. Diat. No. C97644

1. PLACE OF DEATH:

County: Balto

~~City~~ or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

504 E. St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

~~City~~ or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 504 E. St.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW

3.(a) FULL NAME: Edgar E Bissell

3.(b) Social Security Number: none

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Ruth F.

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Sept 13 1868

8. AGE: Years: 79 Months: 1 Days: 27 If less than one day: ... hrs. ... min.

9. Birthplace: Conn (Town, county, and state)

10. Usual occupation: Mill

11. Industry or business:

MOTHER FATHER

12. Name: John E Bissell

13. Birthplace: Conn

14. Maiden name: Ann Cable

15. Birthplace: Pa

16. Informant: Mrs Rose Dieter

Address: 2 Penna Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem

Location: Baltimore Md

18. Funeral director: Wilson & Son

Address: 1214 Pond St.

19. 11-17 1947 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10th 1947, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Nov 10 1947 and that I last saw h[illegible] alive on Nov 10 1947

Immediate cause of death: Carcinoma of Stomach — DURATION: 6 mos.

Due to: ...

Due to: ...

Other conditions: ...

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 520 OSt. Date signed: 11-10-47

VS. A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09747

CERTIFICATE OF DEATH

Reg. Diat. No. 14

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: -

Hospital, institution, or street address where death occurred:
home

How long in hospital or institution?: -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1823 East Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME

Lucian Hagan Blaney

3.(b) Social Security Number

-

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maggie Kelley

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 26, 1856

8. AGE: Years	Months	Days	If less than one day
91			____ hrs. ____ min.

9. Birthplace: Mangahlhah County, Virginia
(Town, county, and state)

10. Usual occupation: Watchman- Farmer

11. Industry or business:

FATHER
12. Name: Issac Blaney
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sally Victor
15. Birthplace: Virginia

16. Informant: Mrs. Queen Blosser

Address: 1823 East Avenue, Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 21, 1947 (month) (day) (year)

Cemetery or crematory: St. Paul's Cemetery

Location: Baltimore, Maryland

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul Street

19. 11/20 19 47 (Date rec'd by registrar) A. W. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26 1947 to Nov. 18 1947 and that I last saw h. alive on Nov. 18 1947

	DURATION
Immediate cause of death: CARDIAC FAILURE	2 WEEKS
Due to: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Stephen C. Mackowiak M.D.
M. D. or other

Address: 6714 Holabird Ave Date signed: Nov 18, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09748

93d QC

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: BALTIMORE - TOWSON (Annex)

City or town: 634 OVERBROOK RD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD County:

City or town: BALTIMORE

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 530 E FORT AVE

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SALLIE BOLANDER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife: GEORGE BOLANDER

6.(c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): APRIL 9, 1865

8. AGE:

Years	Months	Days	If less than one day
82			...hrs. ...min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: FREDERICK GESSNEIN

13. Birthplace: GERMANY

MOTHER

14. Maiden name: SALLIE FELTNER

15. Birthplace: GERMANY

16. Informant: MRS. RUTH ALBERT

Address: 634 OVERBROOK RD.

17. BURIAL. (Burial, cremation, or removal. Which?) Date thereof: NOV. 17, 1947 (month) (day) (year)

Cemetery or crematory: CEDAR HILL

Location: RITCHIE HIGHWAY

18. Funeral director: JOHN F. DENNY, INC.

Address: 715 LIGHT ST.

19. NOV 17 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14, 1947, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 1, 1947 to Nov 14 1947.

and that I last saw h... alive on Nov 14 - 1947

Immediate cause of death	DURATION
- Chronic Myocarditis	6 mos.
Due to - Arterial Hypertension	1 yr.
Due to - Arterio Sclerosis	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: O. D. Mellott M.D. M. D. or other

Address: 1279 Williams St. Date signed: 11/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Mr Chas Chas B. Wheeler

1279 William St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131B

C9749

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: White Hall, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: White Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cleon Oscar Bond

3.(b) Social Security Number: 717-07-8887

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife: Edna L. Bond
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 9 - 1888

8. AGE: Years	Months	Days	If less than one day
59	10	2	hrs. min.

9. Birthplace: Baltimore Co. Md
(Town, county, and state)
10. Usual occupation: Retired Railroad Engineer
11. Industry or business
FATHER 12. Name: Smith Bond
13. Birthplace: Baltimore Co. Md
MOTHER 14. Maiden name: Reno
15. Birthplace: Shrewsbury, Pa
16. Informant: Mrs. F. Dawes Garrett
Address: White Hall, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 14-1947 (month) (day) (year)
Cemetery or crematory: West Lawn
Location: White Hall, Md
18. Funeral director: Howard S. Mashburn
Address: White Hall, Md
19. Nov. 13, 1947 (Date rec'd by registrar) Mrs. Howard S. Mashburn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: On Nov. 11 1947, at 12 15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to Nov. 11 1947
and that I last saw h[illegible] alive on Nov. 11 1947

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: Chronic nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

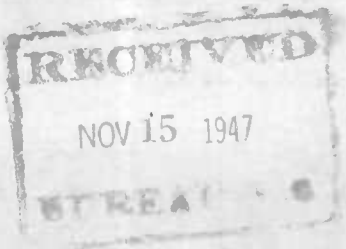
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. W. France M. D. or other
Address: Parkton, Md Date signed: 11/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
NOV 15 1947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 73d

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

(a) Baltimore City, Maryland.

(b) Street address 5501 Edmondson Ave.

(c) Hospital or institution: Hood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 09750

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 623 Rosedale St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claudia Moore Bowen

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: L. Gill

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 18, 1866

8. AGE: Years	Months	Days	If less than one day
81	3	9	hr. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: at Home

FATHER
12. Name
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Charlotte Powell
15. Birthplace: Washington D.C.

16 (a) Informant: Miss Ruth Mahon
(b) Address: 623 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/47 (month) (day) (year)

(c) Cemetery or crematory: Glenwood Cemt.
Location: Washington D.C.

18 (a) Funeral director: Wm. J. Tickner & Sons

(b) Address: North & Pa. Aves.

19 (a) NOV 29 1947 (Date rec'd by registrar) (b) [illegible] M.D. Registrar

11/29/47

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947, at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10, 1947, to Nov. 27, 1947, and that I last saw h[illegible] alive on Nov. 27, 1947.

Immediate cause of death	Duration
Cardiac Failure	2 wks.
Due to Arteriosclerotic cardiovascular disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature George A. Kupp M. D.

Address 3030 Edmondson Avenue Date signed 11/28/47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

37b

BC 09751

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 2 months, 12 dyys

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 4 years, 2 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-23

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2128 West Saratoga Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas A. Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Hattie Ward

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): May 14, 1895

8. AGE: Years	Months	Days	If less than one day
52	5	29	...hrs. ...min.

9. Birthplace: Newark, New Jersey (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Shipyard

FATHER

12. Name: Henry Brown

13. Birthplace: New Jersey

MOTHER

14. Maiden name: Mary Manie ?

15. Birthplace: New Jersey

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 11/14/47 (month) (day) (year)

Cemetery or ~~crematory~~: Meadow Ridge

Location: Dorsey Md.

18. Funeral director: William Cook Inc.

Address: 1217 E. Paul St.

19. Nov 14 1947 (Date rec'd by registrar) A. W. Jefferds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 1947 at 6:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31 1943 to November 12 1947 and that I last saw him alive on November 12 1947

Immediate cause of death	DURATION
Arteriosclerotic cardiovascular disease	years
Due to: Post-encephalitic Parkinsonism	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 11-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

125a

09752

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:
yets. Adm. Hospital, Ft. Howard, Md.

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 732 Bond Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3. (a) FULL NAME: MICHAEL BRZOZOWSKI

3. (b) Social Security Number: 217-07-3366,

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9-16-09

8. AGE: Years	Months	Days	If less than one day
38	2	3	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Walter Brzozowski
13. Birthplace: Poland

MOTHER
14. Maiden name: Lily Popowska
15. Birthplace: Poland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22 47 (month) (day) (year)

Cemetery or crematory: St. Stanislaus

Location: Baltimore, Maryland

18. Funeral director: George A. Weber

Address: 705 S. Ann St. Baltimore, Maryland

19. 11/20/47 19.... (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 19 47 at 9:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1947 to November 19 1947 and that I last saw him alive on November 19 1947

Immediate cause of death	DURATION
Pneumococcus Septicemia	Approx. 3 days
Due to: Pneumonia	
Due to:	

Other conditions: (1) Advanced cirrhosis & necrosis of liver, duration-Unknown (2) Jaundice, duration-Unknown (3) Pneumococcus abscesses of jejunum - duration, Approx. 3 days.
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W.M. Carmine M.D.
W.M. CARMINE, M.D. DEPUTY MED. EXAMINER

Address: Dundalk, 22, Md. Date signed: 11-20-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 22 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

09753

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Hyde, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Hyde, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Green Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARTHA L. BURTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles E. Burton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 22nd, 1883

8. AGE:

Years	Months	Days	If less than one day
64	8	24	..... hrs. ..... min.

9. Birthplace: Balto Co Md

(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: Charles Burton

13. Birthplace: Baltimore County, Md.

MOTHER — 14. Maiden name: Jennie France

15. Birthplace: Baltimore County, Md.

16. Informant: Mrs. Charles R. Wirth, Sr.

Address: 9th Ave., Carney

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/19/47 (month) (day) (year)

Cemetery or crematory: Waugh Chapel

Location: Baltimore County, Md.

18. Funeral director: Lauchs Funeral Home.

Address: 7401 Belair Rd.

19. 11/17/47 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16, 1947 at 8:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 1945 to Nov 10 1947 and that I last saw her alive on Nov 15 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to: Essential Hypertension	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Walter McHammett M. D. or other

Address: Baltimore Date signed 11/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
NOV 19 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09754

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore Maryland.
City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One Day.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore County
(If outside city or town limits, write RURAL and give nearest town)
Street No. 14 Byway North Baltimore 21 Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Warren Bushee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jane Mare Bushee
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): February 26, 1869

8. AGE: Years	Months	Days	If less than one day
78	8	6	..... hrs. ..... min.

9. Birthplace: Canada (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business:

FATHER
12. Name: ? Bushee
13. Birthplace: France

MOTHER
14. Maiden name: Unknown
15. Birthplace: France

16. Informant: Wife
Address: 14 Byway north Baltimore 21 Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov 5-47 (month) (day) (year)
Cemetery or crematory: Pimlico
Location: W. Va.
16. Funeral director: John G Connelly
Address: 408 Eastern Ave

19. Nov-3- 1947 John G Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1947, at 8 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23 1947, to Nov. 3 1947
and that I last saw h.. alive on November 2 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage, Spontaneous	10 days
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Irving B Beck MD (M. D. or other)
Address: 30 Chanbelle Rd Balto 10 Md Date signed: 11/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
DEC 8 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09755

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Baltimore

City or town: Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39yrs

Hospital, institution, or street address where death occurred:

5004 Hazel Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Relay

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5004 Hazel Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LUETTA V. BUXTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Feamle	White	Married

6.(b) Name of husband or wife: Brook L.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	20	hrs. min.

8. Birthplace: Hampshire Co. W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER — 12. Name: Josiah Sirbaugh

FATHER — 13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Harriette Harper

MOTHER — 15. Birthplace: Va.

16. Informant: Mr. Brook L. Buxton

Address: 5004 Hazel Ave. Relay

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/29/47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Ave.

18. Funeral director: Wm. J. Tickner & Sons

Address: North & P. Aves.

19. 11/29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1920, to Nov 27 1947

and that I last saw h... alive on Nov 24 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to: Coronary sclerosis & angina	3 weeks
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frederic U. Reiter M. D. or other

Address: 723 Mercantile Arcade - Balto - Md. Date signed 11-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10524

131a

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 205 W. Chesapeake Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 205 W. Chesapeake Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: (BYUS) Charles W. Byus

3. (b) Social Security Number: 212-07-3826

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Katherine Byus
6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): July 19, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	20	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Stationary Engineer
11. Industry or business: Md. Trust Co., Bldg., Baltimore

FATHER
12. Name: Robert Byus
13. Birthplace: Unknown

MOTHER
14. Maiden name: Carrie F. Danaker
15. Birthplace: Unknown

16. Informant: Mrs. Katherine Byus
Address: 205 W. Chesa. Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Frederick Rd., Baltimore, Md.

18. Funeral director: John Burns Sons
Address: Towson, Maryland

19. Nov 12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1947, at 3 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to November 9 1947
and that I last saw h- alive on October 15 1947

Immediate cause of death	DURATION
Coronary Occlusion	15 Minutes
Due to Arteriosclerosis	5 yrs.
Due to Hypertension Cardio-Vascular Renal Disease	5 yrs
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. S. Charlton M. D. or other
Address: 610 York Rd. Date signed: Nov 7, 47

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JAN 12 1948

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60.

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C9756

132

CERTIFICATE OF DEATH

Reg. Dist. No. 00

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 Days
Hospital, institution, or street address where death occurred: Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 28 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 606 N. Calvert Street (If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: THOMAS F. CALLIGAN

3.(b) Social Security Number: 220-24-4099

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 11-17-85

8. AGE: Years	Months	Days	If less than one day
61	11	19	... hrs. ... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Thomas Calligan
13. Birthplace: Virginia

MOTHER
14. Maiden name: Laura Ginsberg
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 8 47 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: 6501 Frederick Avenue Baltimore, Md.

18. Funeral director: Howard Blight — Howard N. Blight, Jr.
Address: 4914 Belair Road Baltimore, Md.

19. 11/7 19 47 (Date rec'd by registrar) A. W. Hedrich, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6, 19 47, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9, 19 47, to November 6, 19 47 and that I last saw him alive on November 6, 19 47

Immediate cause of death: TUBERCULOSIS, PULMONARY, BILATERAL, WITH CAVITATION, CHRONIC — DURATION: 9 Months plus

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, M.D. M. D. or other
Clinical Director
Address: VAH Fort Howard, Maryland Date signed 11/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48 L.

09757

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Harrisonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Liberty Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Harrisonville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Liberty Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Catherine E. Clark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1879 year not known

8. AGE: Years about 68 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation H W

11. Industry or business

FATHER 12. Name F. Michael Clark

13. Birthplace Ireland

MOTHER 14. Maiden name M. Catherine Elcock

15. Birthplace Ireland

16. Informant Mrs. Gaswold

Address 4716 Park Hts Ave. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/22/47 (month) (day) (year)

Cemetery or crematory Cathedral

Location Baltimore

18. Funeral director C. V. Lemmon

Address 4611 Park Heights Ave

19. 11/21 1947 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1946 19.. to Nov. 20, 1947 and that I last saw h.. alive on Nov. 19, 1947

Immediate cause of death	DURATION
Carcinomatosis	1
Due to	
Carcinoma of uterus	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Date signed 11/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 24 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09758

CERTIFICATE OF DEATH

Reg. Diat. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George Mortimer Coleman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: S. Genevieve Coleman

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 27, 1897

8. AGE: Years	Months	Days	If less than one day
50		25	____ hrs. ____ min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: Auto Parts

11. Industry or business

FATHER
12. Name: George A. Coleman
13. Birthplace: Baltimore City

MOTHER
14. Maiden name: Lizzie Benjamin
15. Birthplace: Baltimore City

16. Informant: George A. Coleman Jr.
Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 24, 1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown, Md.

19. Nov-24-1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 19 47 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-29-36 19 to 11-21 19 47 and that I last saw h[illegible] alive on 11-21-47 19

Immediate cause of death	DURATION
Coronary Thrombosis	6 hrs.
Due to	
Due to	
Other conditions: Bronchio-Pneumonia (Include pregnancy within 3 months of death)	9 days

Major findings of operations: None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Caples, M.D. M. D. or other

Address: Reisterstown, Md. Date signed: 11-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 / 9-45-154

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NOV 26 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1318 09759

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 911 J. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Malinda Fitzgerald Coleman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced?
F	C	M

6.(b) Name of husband or wife: James
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 20 - 1882

8. AGE: Years: 65 | Months: 6 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Keene Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Joseph Oliver
13. Birthplace: Va.

MOTHER
14. Maiden name: Miland Oliver
15. Birthplace: Va.

16. Informant: James Coleman
Address: 911 J. St. Sparrows Pt.

17. B. (Burial, cremation, or removal. Which?) Date thereof 11-28-47 (month) (day) (year)
Cemetery or crematory: Family Plot
Location: Keene Va.
18. Funeral director: Samuel W. Sullivan Jr.
Address: 1011 N. Arlington Ave Balto.
19. Nov. 26 1947 R. W. Fedrick
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25th 1947, at 1:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to November 25-47
and that I last saw her alive on November 25 1947
Immediate cause of death: Bronchopneumonia — DURATION: 10 days
Due to:
Due to: Chronic parenchymatous nephritis — DURATION: June 1947
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. H. Timms M.D.
M. D. or other
Address: Sparrows Pt. Date signed 11/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92b

69760

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS AT5 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
500 Main St Reisterstown Md
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 500 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Emory Summerfield Collins

3.(b) Social Security Number: 717-07-9511

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Elva Cordelia Bouis Collins
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): December 23 1889

8. AGE: Years	Months	Days	If less than one day
57	10	10	...hrs. ...min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Railroad Clerk
11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Mary Estelle Taylor
15. Birthplace: Mt Airy Md

16. Informant: Virginia C Hipple
Address: Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 6 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore Md

18. Funeral director: Wm Berryman & Sons
Address: Reisterstown Md

19. Nov-5-1947 (Date rec'd by registrar) Mary A.E.Line. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3 1947, at 8 P. M.

23. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-6 1945, to Nov. 3 1947, and that I last saw h- alive on Oct 16 1947.

Immediate cause of death	DURATION
Angina Pectoris	2 mo.
Mitral Insufficiency &	2 yrs.
Cardiac Decompensation	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No. Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. D. Caples, M. D. M. D. or other
Address: Reisterstown, Md. Date signed: 11-4-47

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NOV 10 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09761

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs.
Hospital, institution, or street address where death occurred: 25 Bloomsbury Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 25 Bloomsbury Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Catherine Conner

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John T. Conner
6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): May 5, 1873

8. AGE: Years	Months	Days	If less than one day
74	6	19	hrs. min.

9. Birthplace: Ubet-Sleising Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr. Charles Conner
Address: 25 Bloomsbury Ave. Catons

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27, 1947 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Old Frederick Rd. Balto. Md.

18. Funeral director: Easton Sons
Address: 608 Frederick Ave. Catons

19. 11/28/47 (Date rec'd by registrar) Q. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24, 1947, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 1947, to November 24 1947
and that I last saw h. alive on November 24 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr.
Due to, Hypertensive cardio-vascular disease	10 yrs. (?)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer K. Gallagher M.D. M. D. or other
Address: Catonsville-28, Md. Date signed 11/25/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

NOV 28 1947
BUREAU V.S.

COPY SENT TO LOCAL REGISTRAR No. 280 DATE 12/1/47

09762

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137a

CERTIFICATE OF DEATH

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town White Hall Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town White Hall R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Wesley Cordery

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	widower

6.(b) Name of husband or wife Francis Cordery
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 17, 1851

8. AGE: Years 96 | Months 7 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace White Hall Md
(Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business

FATHER 12. Name Thomas Cordery
13. Birthplace unknown

MOTHER 14. Maiden name Frances Berry
15. Birthplace unknown

16. Informant Mrs. Frank Hammond
Address White Hall Md

17. Buried Date thereof Nov. 12-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Pine Grove
Location White Hall Md

18. Funeral director Howard S. Markline
Address White Hall Md

19. Nov. 11, 1947 Mrs Howard S. Markline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November Cystitis-Pyelitis-Chronic, 1947, at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20 1947, to Nov 8 1947
and that I last saw h.i.m. alive on Nov. 8 1947

Immediate cause of death	DURATION
Cystitis	3 wks
Due to Cystitis	2-4 yrs
Due to Chronic prostatic hypertrophy	20 yrs.
Other conditions Malnutrition	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William A Fulton M.D.
M. D. or other
Address Stewartstown Pa. Date signed 11 Nov. 1947

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NOV 13 1947
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

10890

CERTIFICATE OF DEATH

Reg. Diat. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Holbrook

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Holbrook.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Owings Mills.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rosa E. Croft.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow.

6.(b) Name of husband or wife Charles H. Croft.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1875

8. AGE: Years	Months	Days	If less than one day
72	8	4	hrs. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name Wm. Seipe

13. Birthplace Md.

MOTHER 14. Maiden name Unknown.

15. Birthplace Unknown.

16. Informant C. Richard Croft.

Address Holbrook, Balto Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25 1947 (month) (day) (year)

Cemetery or ~~crematory~~ Wesley Chapel

Location Carroll Co. Md.

18. Funeral director Chenoweth & Donovan

Address 3615-17 Chestnut Ave.

19. 11/24/47 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1947, at 4 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23, 1947 to Nov. 23, 1947 and that I last saw her alive on Nov. 23, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown, Md. Date signed 11/23/47

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DEC 22 1947
BUREAU OF

Dr August Ewald 36 York Court

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10616

09763

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Riderwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Riderwood
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Roldrew Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JAMES E. CROSS Sr.

3.(b) Social Security Number: 214-20-2886

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary S.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 27, 1881

8. AGE: Years	Months	Days	If less than one day
66	8	4	..... hrs. ..... min.

9. Birthplace: Laurel, Maryland
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Black & Decker

FATHER
12. Name: James Robert Cross
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary C. Nicoll
15. Birthplace: Baltimore, Maryland

16. Informant: James E. Cross Jr.
Address: Port Deposit, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 6, 1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Maryland

18. Funeral director: William Cook, Inc.

Address: 1217 St. Paul Street

19. Nov 5, 1947 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 19 47 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, 19.., to 19 47

and that I last saw h.i. alive on 11-3 19 47

Immediate cause of death	DURATION
Bronchiectasis	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: A. L. Ewald Jr. M. D. or other

Address: 36 York Ct. Date signed: 11-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

09764

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Baltimore

City or town Boring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Boring (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Georgeanna Sullivan

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W.

6.(b) Name of husband ~~or wife~~ Aaron W Sullivan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 8 - 1856

8. AGE: Years 91 | Months 10 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name unknown

FATHER 13. Birthplace unknown

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant Edgar P Sullivan

Address Boring. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30/47 (month) (day) (year)

Cemetery or crematory Greenmount

Location Carroll Co. Md

18. Funeral director Edw C Shipley

Address Hampstead Md

19. Nov-28-1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947 at 3:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1937 to Nov. 28 1947 and that I last saw h.. alive on Nov. 26 1947

Immediate cause of death	DURATION
Coronary Sclerosis	4 yrs.
Due to Senile Arterio-Sclerosis	12 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE M. C. Porterfield M. D. or other

Address Hampstead Md Date signed 11-28-47

RECEIVED
DEC 3 1947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 09765

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Stanford
(c) Hospital or institution: Comacost Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Yolando Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Curran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife John Curran
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1865

8. AGE: Years 82 | Months | Days | If less than one day: hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Stumsley
13. Birthplace Germany

MOTHER
14. Maiden Name Antonette Corbella
15. Birthplace France

16 (a) Informant Mary Weedon
(b) Address Kenwood Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Lawn
Location Hartford Rd.

18 (a) Funeral director Jas J Steer & Son
(b) Address 3001 Pennsylvania Ave

19 (a) Date received by registrar (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1947, at 2 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Nov 1947, and that I last saw h[illegible] alive on Nov 14 1947.

Immediate cause of death Myocardial failure — Duration 6 Months

Due to Arteriosclerosis - senile

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Waverley Jr. M. D.
Address 2900 Alameda Blvd Date signed 11/14/47

VS 150

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108 09766

BC Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 723 Aisquith Street (If rural, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME MADISON DEPREE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife Widowed 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-1891

8. AGE: Years	Months	Days	If less than one day
56	9	0	hrs. min.

9. Birthplace Branchville, Va. (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name John Depree

13. Birthplace Unknown

MOTHER 14. Maiden name Ida Hart

15. Birthplace Ohio

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-7-47 (month) (day) (year)

Cemetery or crematory

Location Franklin, Va.

18. Funeral director Charles L. Law

Address 802 Madison Ave.

19. Nov 4 1947 J. W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1947 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2, 1947 to November 3, 1947 and that I last saw him alive on November 3, 1947

Immediate cause of death	DURATION
Cirrhosis of liver, portal	Unknown
Due to Unknown	
Due to	
Other conditions Lobar Pneumonia, rt. upper lobe, - duration, Unknown	
Fracture, skull, healed, occipto-parietal (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIRECTOR

Address V.A.H. FORT HOWARD, MD. Date signed 11-3-47

MARGIN RESERVED FOR BINDING

Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. 49 09767

1. PLACE OF DEATH: Co.
(a) Baltimore ~~City~~, Maryland
(b) Street address North Cliff
(c) Hospital or institution:
near Towson
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Stephen Deuerling

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1859

8. AGE: Years	Months	Days	If less than one day
88	—	29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name James Deuerling
13. Birthplace Bavaria Germany

MOTHER
14. Maiden Name Barbara Siebert
15. Birthplace Cumberland, Md.

16 (a) Informant Sr. Mary Clara
(b) Address Notch cliff Md

17 (a) Burial (b) Date thereof Nov. 6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Notch Cliff
Location Glen Arm

18 (a) Funeral director Geo. M. Fritz & Son
(b) Address 811 W. Lafayette Ave.

19 (a) 11/5/47 (b) [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1947, at 9.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1936, to Nov. 4 1947, and that I last saw her alive on Oct 29 1947.

Immediate cause of death	Duration
Myocardial Decompensation	3 mo.
Due to	
Due to	
Other Conditions Arterio sclerosis Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09768

CERTIFICATE OF DEATH

Reg. Diat. No. 41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH

County Balto.

City or town Dundalk 22

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 8138 Bull neck Rd.

How long in hospital or institution? 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Same County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Priscilla Di Domenico.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Divorced

6.(b) Name of husband or wife Salvatore.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30/1880

8. AGE: Years 67 | Months 4 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Pittsburg Pa

(Town, county, and state)

10. Usual occupation Stuff

11. Industry or business Home

FATHER 12. Name Unknown

13. Birthplace Pittsburg Pa.

MOTHER 14. Maiden name unknown

15. Birthplace Pittsburg Pa.

16. Informant Paul V. Domenico (Son)

Address 8138 Bull neck Rd. Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26 1947 (month) (day) (year)

Cemetery or crematory Oaklawn

Location Eastern Ave.

18. Funeral director Roland L. Fisher

Address 2112 Dundalk Ave.

19. 11/26/1947 (Date rec'd by registrar) 19 J. M. Learmont Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947 at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24 1947, to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Learmont, M.D. Deputy Medical Examiner M. D. or other

Address Balto. Co. Dundalk Md. Date signed 11/26/47

RECEIVED
DEC 3 1947

69769

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Diat. No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, Institution, or street address where death occurred:
1715 Magnolia Ave.
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. Virginia County
City or town Louisa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
Sarah Byrd Donnally

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
about 81			hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Jesse Porter
13. Birthplace Virginia

MOTHER
14. Maiden name Gabrelle Jones
15. Birthplace Virginia

16. Informant Mrs. Jesse A. Donnally
Address Charlottesville, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/19/47 (month) (day) (year)
Cemetery Hillcrest
Location Louisa, Virginia

18. Funeral director John O. Mitchell & Sons, Inc.
Address 1900 Eutaw Place, Baltimore-17-Md.

19. 11/19/47 (Date rec'd by registrar) A.W. Yedrich Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1947, at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1947 to Nov. 16 1947 and that I last saw h.er alive on November 16 1947

Immediate cause of death	DURATION
Broncho-pneumonia, bilateral	3 days
Due to	
Due to 59 Ca	
Other conditions Arthritis, chronic, mild type, severe (Include pregnancy within 3 months of death)	20 yrs.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lee J. Gore M.D.
M. D. or other
Address 1 Mallow Hill Ave. Date signed 11/16/47

RECEIVED
NOV 19 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C 09770

Reg. Diat. No. 44

MV

1. PLACE OF DEATH:
County Balto.
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Route 40 Atlantic Highway
How long in hospital or institution? Near Belgian Village

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State New York County
City or town New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 375 East 184th Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Corpnal William J Dorgan

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): January 6th 1929
8. AGE: Years 18 | Months 9 | Days 2 | If less than one day ..... hrs. ..... min.
9. Birthplace New York City N Y (Town, county, and state)
10. Usual occupation U.S. marine Corps
11. Industry or business
FATHER 12. Name Stanton Dorgan
13. Birthplace New York
MOTHER 14. Maiden name Catherine Murray
15. Birthplace Dunbar Pennsylvania
16. Informant Stanton Dorgan (Father)
Address 375 E. 184th St New York
17. Removal (Burial, cremation, or removal. Which?) Date thereof 11-10-47 (month) (day) (year)
Cemetery or crematory Holt Cemetery
Location Lindenwold, New Jersey
18. Funeral director John S. Connolly
Address 1418 Eastern Ave.
19. 11-10-47 (Date rec'd by registrar) 19 John S Connolly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 19 47 at 3 30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Fractured cervical vertebra	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide~~, or homicide Accident Date of 11/8/47
Where did injury occur? Middle River (City or town) Balto (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Road.
Means of injury Auto hit Guard Rail Injured at work? No.

23. SIGNATURE D McCormone M.D.
Address Dundalk Md. Deputy Medical Examiner Date signed 11/8/47.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 19 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09771

CERTIFICATE OF DEATH

Reg. Dist. No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Balto.

City or town Middle River (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Ebenezer Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Same County as in I

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Joseph Draayer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Clara E. Draayer

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5th 1887

8. AGE:

Years	Months	Days	If less than one day
60	2	2	hrs. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual occupation Truck farmer

11. Industry or business farming

FATHER 12. Name Harmon Draayer

13. Birthplace Balto Co. Md.

MOTHER 14. Maiden name Theresa Porter

15. Birthplace Germany

16. Informant Mrs. S. S. Draayer

Address Ebenezer Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11th 1947 (month) (day) (year)

Cemetery or crematory Parkwood

Location Balto. City Md.

18. Funeral director Lansdowne Funeral Home

Address 7401 Belair Rd.

19. Nov. 8 1947 (Date rec'd by registrar) John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1947 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 7 1947 and that I last saw him alive on Nov 7 1947

Immediate cause of death Coronary Thrombosis — DURATION: Sudden

Due to Arteriosclerotic Cardio Vascular disease — DURATION: 1 yr

Due to — DURATION:

Other conditions — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. M. Baumgardner M. D. or other

Address Balto 6 Md. Date signed 11-7-47

RECEIVED
NOV 28 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

10898

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: BALTIMORE

City or town: TOWSON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 5 months, 7 days

Hospital, Institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or institution? 6 years, 5 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 316 Cumberland Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: EINSTEIN, BEATRICE OTTINGER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Adolf Einstein

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 29, 1882

8. AGE: Years	Months	Days	If less than one day
65	3	22	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: --

FATHER — 12. Name: Adolf Ottinger

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Dinah Leon

MOTHER — 15. Birthplace: ~~unknown~~ New Jersey

16. Informant: HOSPITAL RECORDS

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 24, 1947 (month) (day) (year)

Cemetery or crematory: Oakdale

Location: Wilmington, N.C.

18. Funeral director: Wm. J. Tickner & Sons

Address: North & Pa. Ave.

19. Nov 24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21, 1947, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14th 1941 to November 21 1947 and that I last saw her alive on November 21, 1947

Immediate cause of death	DURATION
Generalized arterio-sclerosis; chronic myocardial degeneration	6 years
Due to:	
Due to:	
Other conditions: Chronic nephritis; cirrhosis of liver not due to alcohol	6 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirms above. Also, pericarditis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W.W.Elgin W.W.Elgin, M.D. M. D. or other

Address: Towson 4, Md. Date signed: 11/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 12 1948
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09772

93a

CERTIFICATE OF DEATH

Reg. Diat. No. 37

1. PLACE OF DEATH:
County Baltimore
City or town Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yr 2 mo. 22 da.
Hospital, Institution, or street address where death occurred:
Baltimore County Home.
How long in hospital or institution? 5 yr. 2 mo. 22 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Baltimore
City or town Phoenix
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Peter Christofer Eppers

3.(b) Social Security Number 212-12-0855

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife Margaret Walters
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1881

8. AGE: Years	Months	Days	If less than one day
66	3	3	..... hrs. ..... min.

9. Birthplace Iowa. Penna. (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business
FATHER 12. Name Nicholas Eppers
13. Birthplace Germany
MOTHER 14. Maiden name Margaret Lick
15. Birthplace Germany
16. Informant Balto. County Home Register
Address Texas. Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20-1947 (month) (day) (year)
Cemetery or crematory Baltimore County Home Cem
Location Texas. Md.
18. Funeral director Landon Brooks
Address Sparks. Md.
19. Nov. 19 1947 Wm J. Schilcoat Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1947, at 7 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 27 1947, to 11/18 1947
and that I last saw h... alive on 11/18 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to Arteria sclerosis	
Due to	
Other conditions 3rd attack — Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Holmes C. Emrich M. D
M. D. or other
Address Cockeysville Md. Date signed 11/19/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 24 1947
BUREAU

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09773

160C

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Balto.
City or town Dundalk 22 (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Bartlo Kowski Dr. & North Pt Rds. New Battlegrove
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Same County
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Infant, Evans.
3. (b) Social Security Number

4. Sex Fem
5. Color or race Col.
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years / Months / Days / If less than one day ... hrs. 5 min.
9. Birthplace Md. Balto (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name William Barksdale
13. Birthplace Va.
MOTHER 14. Maiden name Marinda Evans
15. Birthplace Va.
16. Informant Marinda Evans (mother)
Address above.
17. Burial Date thereof Nov. 29, 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md
18. Funeral director Elroy O. Wilson
Address 1000 Brantley ave
19. 11/29 1947 (Date rec'd by registrar) A W Hedrick Dr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1947, at 1 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1947, to ... 19...
and that I last saw h... alive on ... 19...
Immediate cause of death Atelectasis.
Due to Suffocation after birth.
Due to
Other conditions
(Include pregnancy within 3 months of death)
DURATION
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide or homicide~~ accident. Date of
Where did injury occur? Dundalk Balto Md (City or town) (County) (State)
Injured at home, farm, industry, public place, (where?) At Home
Means ~~of injury~~ not resuscitated after birth. Injured at work? No.
23. SIGNATURE W M Cannine M.D. Deputy Medical Examiner M.D. or other
Address Balto. Co. Dundalk 22 Md. Date signed 11/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d BC 09773

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH: Balto
County
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred: Cassell Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore No.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3132 Chesley Ave
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Adelaide C. Ford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26. 1861

8. AGE: Years 86 Months 8 Days 2 If less than one day hrs. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual occupation School Teacher

11. Industry or business Retired

FATHER 12. Name John T. Ford

13. Birthplace Md.

MOTHER 14. Maiden name A. Chasteau

15. Birthplace Unknown

16. Informant Mr. J. S. Bowlsbey

Address 3132 Chesley Ave Balto. Md.

17. Buried (Burial, cremation, or removal) Date thereof Dec. 1. 47 (month) (day) (year)

Cemetery or crematory Alon Lawn

Location Elkton Md

18. Funeral director Dempsey Gipson

Address 3132 Chesley Ave

19. 11/29/47 (Date received by registrar) A.P. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28. 1947, at 10. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3, 1944, to Nov. 28, 1947 and that I last saw her alive on Nov. 28 1947

	DURATION
Immediate cause of death Myocardial Failure	3 days
Due to Chronic Myocarditis	3½ years
Due to ✓	
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. ✓

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur? ✓ ✓ ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓

Means of injury ✓ Injured at work? ✓

23. SIGNATURE Frank M. Ogden, M.D. M. D. or other

Address 2701 N. Calvert St. Date signed Nov. 29, '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

09775

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7619 Belair Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SAMUEL H. FOULKE

3.(b) Social Security Number: 212-12-9363

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widower

6.(b) Name of husband or wife: Mary E. Foulke

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 16th, 1866

8. AGE: Years: 81 Months: 5 Days: 27 If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: Contractor & Builder

11. Industry or business

FATHER
12. Name: John R. Foulke
13. Birthplace: Pa.

MOTHER
14. Maiden name: Catherine A. Hall
15. Birthplace: Del.

16. Informant: Mrs. Milton Evans
Address: 7619 Belair Rd.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/17/47 (month) (day) (year)

Cemetery or crematory: Parkwood
Baltimore, Md.

Location

18. Funeral director: Lasahn Funeral Home
Address: 7401 Belair Rd.

19. Nov. 14 (Date rec'd by registrar) 19 47 Mrs. G. L. Rispnidy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13th, 19 47 at 2:30a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10th 19 47 to Nov 13 19 47 and that I last saw h... alive on Nov 12th 19 47

	DURATION
Immediate cause of death: Coronary Thrombosis	4 days
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: L Edwin Benson M. D. or other

Address: 1 W. Oregon Ave. Date signed 11/14/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 18 1947
BUREAU

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 40 09775

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto
(b) Street address Towson
(c) Hospital or institution: Notch Cl. FF
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Davidica Franz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1871

8. AGE: Years	Months	Days	If less than one day
76	8	15	hr. min.

9. Birthplace Buffalo N. Y. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Joseph Franz
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Kam
15. Birthplace Germany

16 (a) Informant Sr. Mary Clara
(b) Address Notch Cliff

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/47 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff
Location Glen Eden

18 (a) Funeral director Geo M. Fenwick Son
(b) Address 811 Reservoir St

19 (a) 11/24/47 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1947, at 6.25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1940, to Nov. 20 1947, and that I last saw her alive on Nov. 19 1947.

Immediate cause of death	Duration
Coronary occlusion	10 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address Date signed

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52b ac 09777

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 96 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.

How long in hospital or institution? 96 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1314 Homewood Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME

HARRY A. FRARY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes Frary

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 8-1-90

8. AGE: Years	Months	Days	If less than one day
57	2	30	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Beautician

11. Industry or business

FATHER
12. Name: Harry L. Frary
13. Birthplace: Meridan, Conn.

MOTHER
14. Maiden name: Julia S. Myers
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4 1947 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore

18. Funeral director: Rita Wiedefeld

Address: 900 East Biddle St.

19. Nov 3 1947 (Date rec'd by registrar) H. W. Hedreck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1, 1947 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1947, to November 1, 1947 and that I last saw him alive on November 1, 1947

Immediate cause of death	DURATION
Carcinoma of the Bladder	4 Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or Other
R. M. CULLISON, M. D. CLIN. DIR.

Address: V.A.H. FORT HOWARD, MD. Date signed: 11-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09778

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? ----------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Maiden Choice Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3. (a) FULL NAME: Alphonse Frederick Gauges

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ---------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): ----- [illegible] 1863

8. AGE: Years	Months	Days	If less than one day
About 64	---	--	-- hrs. -- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Philip Gauges

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Anna Frederick

15. Birthplace: Baltimore, Maryland

16. Informant: Very Rev. Geo. A. Gleason, D D

Address: St. Charles' College

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28/47 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Md.

16. Funeral director: H. W. Meares and Son

Address: 805 N. Calvert Street

19. Nov. 26 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 1947, at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and thet I last saw h..... alive on ..... 19...

Immediate cause of death	DURATION
Acute cardiac failure	
Due to: Cardio vascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. J. McKieffer Certified Signed M. D. or other

Address: 1010 Lenham Date signed Nov. 25 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

195d BC 09779 44

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Approx. 14 Hrs.

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or Institution? Approx, 14 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1708 Light St., or
134 N. Pearl St. (If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: SEGAL GOINS

3.(b) Social Security Number: 212-26-9839

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6-16-22

8. AGE: Years	Months	Days	If less than one day
25	5	3	hrs. min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: Shipyard worker

11. Industry or business:

FATHER
12. Name: Critten Goins
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Florence Foster
15. Birthplace: Kentucky

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 28 47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cem.

Location: Baltimore, Md.

18. Funeral director: Howard M. Blight, Jr.
Address: 4914 Belair Rd., Balto., Md.

19. 11-28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 1947, at 1:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24, 1947, to November 25, 1947 and that I last saw h... im alive on November 25, 1947

Immediate cause of death	DURATION
Aspiration of bloody vomitus;	Sudden
obstruction of bronchi by bloody mucus	
Due to: Unknown	
Due to:	
Other conditions: Jaundice, Due to: Unknown	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. M. Carmine M.D.
W. M. CARMINE, Deputy Med. Examiner

Address: Dundalk, 22, Md. Date signed 11-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52a

09780

CERTIFICATE OF DEATH

Reg. Dist. No. 84

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Grave Run
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town: Grave Run
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Paul G Gorr

3.(b) Social Security Number: 213-10-0745

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Margaret M Winemiller
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): January 3, 1899

8. AGE: Years	Months	Days	If less than one day
48	10	20	hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Spencer Gorr
13. Birthplace: Md

MOTHER
14. Maiden name: Geethela Hoover
15. Birthplace: Md

16. Informant: Mrs Paul Gorr
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 28 47 (month) (day) (year)
Cemetery or crematory: Middletown
Location: Balto Co Md
18. Funeral director: Edw A Tipton
Address: Hampstead Md

19. Nov. 24 1947 (Date rec'd by registrar) C E Fowble M.D Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1947, at 4 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1947 to Nov 23 1947
and that I last saw him alive on September 20 1947

Immediate cause of death	DURATION
Carcinoma Left Kidney	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma Left Kidney
Date of op. 5-19-47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jos E Buckman M. D. or other
Address: Hampstead Md Date signed: 11-23-47

RECEIVED
NOV 26 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a 09781

CERTIFICATE OF DEATH

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: 616 Main St Reisterstown

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 616 Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: William Thomas Gore

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mary E Brown Gore

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): October 2 1866

8. AGE: Years 81 | Months 1 | Days 22 | If less than one day: ...hrs. ...min.

9. Birthplace: Reisterstown Balto Co Md (Town, county, and state)

10. Usual occupation: Retired County Employe

11. Industry or business: -

FATHER — 12. Name: Thomas J Gore

FATHER — 13. Birthplace: Reisterstown Md

MOTHER — 14. Maiden name: Elizabeth Berryman

MOTHER — 15. Birthplace: Reisterstown Md

16. Informant: Mrs Frances Pattinson

Address: 616 Main St Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 27 1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Pikesville Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. Nov 26 1947 (Date rec'd by registrar) Mary B Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 1947, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-21 1947, to 11-24 1947

and that I last saw him alive on 11-24 1947

Immediate cause of death	DURATION
Arteriosclerosis	2 yrs.
Due to	
Due to	
Other conditions: Bilateral Hernia (Inguinal)	40 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Caples, M.D. M. D. or other

Address: Reisterstown, Md Date signed: 11-26-47

RECEIVED
NOV 29 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

09782

Reg. Diat. No. 2

1. PLACE OF DEATH:
County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
1326 Poplar Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1326 Poplar Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Andrew Griffin

3.(b) Social Security Number: 216 01 3514

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothea Behlert Griffin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 12, 1891.

8. AGE:

Years	Months	Days	If less than one day
56	4	27	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Butler Bros.

FATHER
12. Name: William Griffin
13. Birthplace: Md.

MOTHER
14. Maiden name: Rose Rice
15. Birthplace: Ireland

16. Informant: Mrs. Dorothea Griffin
Address 1326 Poplar Ave. Arbutus, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13/47 (month) (day) (year)
Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18. Funeral director: Harry H. Nitzke
Address 4101 Edmondson Ave.

19. 11 12 47 (Date rec'd by Registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1947. 19 ..... at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 47, to Nov 9 19 47
and that I last saw h~~im~~ alive on 11/9/47 19 .....

	DURATION
Immediate cause of death: Hypostatic pneumonia	
cardiac failure	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Benjamin Welles M. D. or other
Address 1330 Whitelock Ave. Date signed 11/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ineligible or illegible age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09783

CERTIFICATE OF DEATH

Reg. Dist. No. 3d

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Hoode Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: formerly of Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1930 Gwynn Oak Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Amelia Haldy

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Frederick Haldy

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): May 1, 1856

8. AGE: Years	Months	Days	If less than one day
91	6	16	... hrs. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: George Wise

13. Birthplace: Frankfort on Main Germany

MOTHER — 14. Maiden name: Elizabeth Schaape

15. Birthplace: Frankfort Germany

16. Informant: Mr. Arthur Wise

Address: 1816 Chilton Ave. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 19, 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Ave. Baltimore

18. Funeral director: Easton Sons

Address: 608 Frederick Ave. Catonsville Md

19. Nov. 18 1947 (Date rec'd by registrar) J. Carroll Wagamaker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 17, 1947, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7 1943, to Nov. 17 1947, and that I last saw her alive on Nov. 15 1947

Immediate cause of death	DURATION
Broncho-Pneumonia	1 week
Due to	
Due to	
Other conditions: 1. Myocardial Degeneration	3 yrs
2. High Blood Pressure	2 years
3. Senility	

(Include pregnancy within 3 months of death)

Major findings of operation: None ... Date of op. ...

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Joshua N. Armacost M.D. (M. D. or other)

Address: 6419 Windsor Mill Rd. Date signed: 11/18/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Herman

RECEIVED
NOV 19 1947
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 L

09784

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 109 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 109 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4732 Amberley Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-1

3. (a) FULL NAME: KEMPER HARGEST

3. (b) Social Security Number: UNKnown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Hargest

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): April 7, 1896

8. AGE: Years	Months	Days	If less than one day
51	7	1	..... hrs. ..... min.

9. Birthplace: Fullerton, Maryland
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business

FATHER
12. Name: Thomas Hargest
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Anna Stinger
15. Birthplace: Ohio

16. Informant: Vets. Adm. Hosp. Clinical Records

Address: Fort Howard, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/12/47 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore, Md.

18. Funeral director: Lasaahn Funeral Home

Address: 7401 Belair Rd.

19. Nov 15 1947 (Date rec'd by registrar) Dawson L. Farber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1947 at 1:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1947 to Nov. 8 1947 and that I last saw him alive on November 8 1947

Immediate cause of death: HEART DISEASE - CORONARY ARTERIOSCLEROSIS - MYCARDIAL INFARCTION — DURATION: 2 days

Due to: ..... plus

Due to: .....

Other conditions: Pulmonary Tuberculosis, chronic, active, moderately advanced. 10 yrs.
(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R J Covalesi M D
M. D. or other

Address: V.A.H. Fort Howard, Md. Date signed: 11-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
NOV 18 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 b 09785 30

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 82 Winters Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Daniel Harris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary L.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1866

8. AGE: Years	Months	Days	If less than one day
81			hrs. min.

9. Birthplace: Baltimore Co. Md. (town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Daniel Harris
13. Birthplace: Maryland

MOTHER
14. Maiden name: Charlotte Lindsay
15. Birthplace: Maryland

16. Informant: Mrs. Mary L. Harris
Address: 82 Winters Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 25, 1947 (month) (day) (year)
Cemetery or crematory: Western Star
Location: Catonsville, Md.

18. Funeral director: Mrs. George H. Hallam
Address: 1631 Druid Hill Ave

19. 11-24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 1947 at 9.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-6-47 19 to 11-22-47 19
and that I last saw h alive on 11-22-47 19

Immediate cause of death	DURATION
Acute Myocarditis	2 days
Due to: Bronchio-Pneumonia	14 "
Due to: Hypertensive Arterio Sclerosis	5
Other conditions: Mitral Insufficiency	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. F. Maloney M.D. M. D. or other
Address: Catonsville, Md. Date signed: 11/24/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

90 b pc 09786

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 33 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1502 Partridge Court
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: STERLING HARRIS

3.(b) Social Security Number: 219-05-5102

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ethel Harris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4-5-98

8. AGE: Years	Months	Days	If less than one day
49	7	0	..... hrs. ..... min.

9. Birthplace: Petersburg, Va.
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business

FATHER — 12. Name: Richard Harris

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Betty E. Austin

15. Birthplace: Petersburg, Va.

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/10/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Charles R. Law

Address: 802 Madison Ave., Balto., Md.

19. Nov 7 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5, 1947 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3, 1947 to November 5, 1947 and that I last saw him alive on November 5, 1947

Immediate cause of death	DURATION
Pericarditis adhesive,	Unknown
Due to: Unknown	
Due to:	
Other conditions: Tumor of right pleura, type undet., Due to: Unknown	2 Yrs. plus

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLINICAL DIRECTOR

Address: V.A.H., FORT HOWARD, MD. Date signed: 11-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of date of birth and age is shown on G113 12/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09787 44

Reg. Dist. No. ..... Reg. No. .....

1. PLACE OF DEATH:

County ..... BALTIMORE

City or town ..... Sparrows Point. 19. Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... UNKNOWN

Hospital, Institution, or street address where death occurred:

6916 NORTH POINT ROAD

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... MARYLAND ..... County ..... BALTIMORE

City or town ..... Sparrows Point. 19. Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... 6916 NORTH POINT ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war ..... WORLD WAR I

3.(a) FULL NAME GEORGE LEROY HARVEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ..... CECILIA (nee O'LEARY)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APRIL 12, 1893

8. AGE: Years	Months	Days	If less than one day
55 54	7	9	..... hrs. ..... min.

9. Birthplace ..... Baltimore, Maryland (Town, county, and state)

10. Usual occupation ..... RESTAURANT MANAGER

11. Industry or business .....

FATHER

12. Name ..... UNKNOWN

13. Birthplace ..... UNKNOWN

MOTHER

14. Maiden name ..... UNKNOWN

15. Birthplace ..... UNKNOWN

16. Informant ..... CECILIA HARVEY (wife)

Address 6916 NORTH POINT ROAD

17. ..... BURIAL ..... Date thereof ..... 11-24-1947 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory ..... HOLY REDEEMER CEM.

Location ..... BELAIR ROAD, BALTIMORE, MD.

18. Funeral director ..... LILLY & ZEILER INC.

Address ..... 403 S. WOLFE ST. BALTIMORE, MD.

19. NOV. 22. 1947 Dawson L. Harbr

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... November 21. 1947, at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1942, to Nov 21. 1947

and that I last saw ~~him~~ alive on Nov 20. 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hrs
Due to Hypertension Arterio-sclerotic Cardio-Vascular disease	5 yrs
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — ..... Date of op. .....

Autopsy results — .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dawson L. Harbr M. D. or other

Address Sparrows Point Md. Date signed 11/22/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Farber
914 D St.
Sparrows Pt.
phone S. Pt. 146

RECEIVED
NOV 25 1947
FBI

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a BC

09788

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 340 W. Preston Sts.
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3.(a) FULL NAME JOHN P. HARVEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married--Separated

6.(b) Name of husband or wife Beatrice Harvey

6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 8-20-95

8. AGE: Years	Months	Days	If less than one day
52	2	14	...hrs. ...min.

9. Birthplace Charlotte Co., Va.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Robert L. Harvey

13. Birthplace Virginia

MOTHER 14. Maiden name Jimia Brown

15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 7 47 (month) (day) (year)

Cemetery or crematory Balto. National Cem

Location Dev Frederick Rd

18. Funeral director Chas P. Carr

Address 807 Madison - #1.

19. 11/5/47 (Date rec'd by registrar) 19... J. McLearnon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1947 at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29, 1947 to November 4, 1947 and that I last saw him alive on November 4, 1947

Immediate cause of death	DURATION
MENINGITIS	7 days
Due to Fracture of base of Skull	10 days
Due to	
Other conditions Acute Sinusitis of Sphenoid and Ethmoid Sinuses (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op. ...

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/25/47

Where did injury occur? Baltimore (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell down steps Injured at work? No

23. SIGNATURE J. McLearnon M.D.
(M.D. or other)

Address Dundalk Md. Date signed 11/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
NOV 7 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09789

13b 33

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos 12 days

Hospital, institution, or street address where death occurred:

Rosewood State Training School.

How long in hospital or institution? 2 mos 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Lorraine Vera Heller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 16, 1934

8. AGE:

Years	Months	Days	If less than one day
13	4	23	hrs. min.

9. Birthplace: Baltimore Co. Md.

(Town, county, and state)

10. Usual occupation: Inmate

11. Industry or business

FATHER

12. Name: Vernon Heller

13. Birthplace: Baltimore Co Md

MOTHER

14. Maiden name: Hilda Frei

15. Birthplace: Baltimore

16. Informant: Rosewood State School Parole

Address: Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 10th (month) (day) (year)

Cemetery or crematory: Pinewood Cem

Location: Rural

18. Funeral director: Ulrich Funeral Home

Address: 2008 Orleans St

19. 11/10 1947 C.W. Hedrich Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 1947, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947, to November 7 1947

and that I last saw h... alive on November 7 1947

Immediate cause of death	DURATION
Recurrent	
Pulmonary Hemorrhage	16 hrs
Due to: Pulmonary Tuberculosis	2 Mos +
Due to:	
Other conditions: Congenital Spastic Diplegia	Life.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Isabel H. McClenahan M.D.

M. D. or other

Address: Rosewood Owings Mills Md. Date signed: Nov 7 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09790

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH

County: Baltimore

City or town: Catonsville Manor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Montjomery Rd
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William H. Hipsley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widow

6.(b) Name of husband or wife: late Margaret Lanehardt

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar 8, 1861

8. AGE: Years	Months	Days	If less than one day
86	0.	14	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: —

FATHER
12. Name: —
13. Birthplace: Md.

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Mrs. Elsie Caldwell

Address: 233 S. Fulton Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-25-47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3801 Frederick Ave

18. Funeral director: Harry N Witzke

Address: 4101 Edmondson Ave.

19. 11-24 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 19 47 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 25 19 42 to Nov. 22 19 47 and that I last saw him alive on Nov. 22 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days.
Due to: Arteriosclerosis	?
Due to: Senility	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Samuel E. Boyd M.D. M. D. or other

Address: 1905 W. Baltimore St. Date signed: 11/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 09791

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural - Fork
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Rural - Fork
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOSEPH HLISTA

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1862

8. AGE: Years	Months	Days	If less than one day
85	9	10	hrs. min.

9. Birthplace: Austria
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: John Hlista
13. Birthplace: Austria
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: O. Ruff
Address: Hyde Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13-47 (month) (day) (year)
Cemetery or crematory: Fork M. E. Cem
Location: Fork Md.
18. Funeral director: Clarence E. Authurs
Address: Fork Md.
19. Nov. 12 1947 (Date rec'd by registrar) C. E. Authurs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11 1947 at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 1947, to Oct 20 1947
and that I last saw him alive on Oct 20 1947

Immediate cause of death	DURATION
Chr. Myocardial Disease	>
Due to	
Due to	
Other conditions Chr. Cardio-Vascular Disease.	5 yrs?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed 11/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 17 1947
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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

09792

Reg. Diat. No. 40

1. PLACE OF DEATH:
County: Balto.
City or town: Perry Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Belair Road and Walter Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Perry Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Belair Road & Walter Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY ELIZABETH HOFFMEISTER

3.(b) Social Security Number: none

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Albert Hoffmeister
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 25, 1868
8. AGE: Years: 79 Months: 2 Days: 19 If less than one day: hrs. min.
9. Birthplace: Balto. Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: August R. Schroeder
13. Birthplace: Germany

MOTHER
14. Maiden name: Pauline Rader
15. Birthplace: Unknown

16. Informant: Mr. Albert Hoffmeister
Address: Perry Hall, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18, 1947 (month) (day) (year)
Cemetery or crematory: St. Michaels Lutheran
Location: Perry Hall, Md.

18. Funeral director: Landsdale Funeral Home
Address: 7401 Belair Road

19. 11/17/47 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14th, 1947 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 1947 to Nov 14 1947
and that I last saw h[illegible] alive on Nov 14 1947

	DURATION
Immediate cause of death: Uremia	1 wk.
Due to: Arterio Sclerotic Cardio vascular-Renal disease	2 yrs
Due to:	
Other conditions: Diabetes Mellitus	2 yrs
Cerebral apoplexy	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Balto 6 Md. Date signed 11-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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NOV 19 1947
BUREAU OF

C9793

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95C

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 23 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME
Eileen Louise Hogan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: --
7. Birth date of deceased (mo., day, yr.): October 22, 1915

8. AGE: Years	Months	Days	If less than one day
32	1	8	hrs. min.

9. Birthplace: Canandaigua, Ontario Co. N.Y. (Town, county, and state)
10. Usual occupation: ---
11. Industry or business: ---

FATHER
12. Name: Joseph V. Hogan
13. Birthplace: Watertown, N.Y.

MOTHER
14. Maiden name: Margaret Louise Quigley
15. Birthplace: Canandaigua, N.Y.

16. Informant: Rosewood State Training School
Address: Owings Mills, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/47 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore, Md.
18. Funeral director: H. C. Meads and Son
Address: 805 N. Calvert Street

19. 12/2/47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 19 47 at 11.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 1924 19 to Nov. 30 19 47
and that I last saw her alive on November 30 19 47

Immediate cause of death	DURATION
1. Cardiac Insufficiency with complicating pulmonary edema	1 hr.
Due to 2. Grand mal seizures recurrent.	Since birth
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. G. Butler M.D. (HH) M. D. or other
Address: Owings Mills, Md. Date signed: Dec. 1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09794

131a

Reg. Diat. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Essex, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Essex, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1401 E. Homberg Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY K. HOMBERG

3. (b) Social Security Number

Husband #. 214-07-8541

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Anton Homberg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 20th, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	30	..... hrs. ..... min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: John Brehm

13. Birthplace: Germany

MOTHER — 14. Maiden name: Janette Lawrence

15. Birthplace: Germany

16. Informant: Mr. Anton Homberg

Address: 1402 E. Homberg Ave.

17. burial — Date thereof: 11/23/47 (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory: Zion Lutheran

Location: Essex, Md.

18. Funeral director: Lassahn Funeral Homes

Address: 7401 Belair Rd.

19. Nov 1 19 47 Thos G Donelly Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

p

20. DATE OF DEATH: Nov. 19th 19 47 at 7:12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	Hours
Due to Hypertension	One
Due to Coronary Sclerosis	3
Due to	Yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. J. McGuire M.D.
M. D. or other
Deputy Health Officer
Address: Balto. Co. Date signed 11/21/47
Licensed Md.

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NOV 28 1947
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95 b

09795

CERTIFICATE OF DEATH

Reg. Dist. No. 35-

1. PLACE OF DEATH:

County: Baltimore

City or town: Freelands, R.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: Baltimore

City or town: Near Hoffmanville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ima Homemaker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harvey E. Homemaker

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1881

8. AGE:

Years	Months	Days	If less than one day
66	8	6	...hrs. ...min.

9. Birthplace: Baltimore Co. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Adam Henry Francis Bull

13. Birthplace: Baltimore Co.

MOTHER

14. Maiden name: Laura Belle Housman

15. Birthplace: Baltimore Co.

16. Informant: Harvey E. Homemaker

Address: Freeland Md.

17. (Burial, cremation, or removal. Which?) Date thereof: Nov 12 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Middletown Md.

Location

18. Funeral director: J. Jacob Hartenstein

Address: New Freedom Pa.

19. Nov 10 1947 (Date rec'd by registrar) Edgar L. Preston Registrar

Date rec. by me: Nov. 14, 1947 H.S.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9 1947, at 2.50 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-25 1940, to 11-9 1947

and that I last saw her alive on 11-9 1947

	DURATION
Immediate cause of death: Cerebral Embolism	8 hours
Due to: Auricular Fibrillation	2 yrs
Due to: Rheumatic Heart Disease	15 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Louis Lalatanoff M.D. M.D. or other

Address: New Freedom, Pa. Date signed: 11-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

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NOV 26 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Dist. No. 0979633

PLEASE WRITE PLAINLY, WITH INKING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: County: Baltimore; City or town: Owings Mills (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 3½ years; Hospital, institution, or street address where death occurred:; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Maryland; County: Baltimore; City or town: Owings Mills (If outside city or town limits, write RURAL and give nearest town); Street No.: Gwynnbrook Avenue (If rural, give LOCATION); 2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Susan Elizabeth Hopkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Finks Hopkins

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 29-1876

8. AGE:

Years	Months	Days	If less than one day
71	7	3	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER — 12. Name: Daniel F. Allen; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Isabelle Boyer; 15. Birthplace: Maryland

16. Informant: Mrs. Margaret L. Bailey; Address: Gwynnbrook Ave. Owings Mills

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 5-1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Maryland

18. Funeral director: Burgee Funeral Home

Address: 3631 Falls Road, Baltimore

19. Nov. 4 1947 J. W. Hedrick (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2 - 1947, at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947, to Nov. 2 1947, and that I last saw her alive on Nov. 2 1947.

	DURATION
Immediate cause of death: Cardiac Asthenia	8 hrs.
Due to: Cardio Vascular Renal	8 yrs
Due to: Hypertension	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dr E W Comm M. D. or other

Address: 1202 St Paul St Date signed: 11/4/47

Dr. Earle H. Koons
1202 St. Paul St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

09797

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:

County Balto.

City or town Essex 21

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

446 Eastern ave (Essex

How long in hospital or institution? 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 155 Riverside Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Everett (Clayton) Horton

3.(b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6.(b) Name of ~~husband or~~ wife Margaret Horton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 26/1876

8. AGE: Years 71 | Months 7 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation Window Polisher

11. Industry or business National Window Cleaning Co.

FATHER 12. Name (Not Known) Horton

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Margaret Horton

Address 155 Riverside Ave. - Essex

17. ~~(Burial, cremation, or removal. Which?)~~ Burial Date thereof 12/1/47 (month) (day) (year)

~~Cemetery or crematory~~ London Park

Location Balto. Md.

18. Funeral director William Cook Inc.

Address 127 St. Paul St.

19. 11/29 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1947 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1947, to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary accident	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. McGarrigle M. D.

Deputy medical Exp. M.D. or other

Address Balto. Co. Brooklyn Date signed 11/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47e BC

09798

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 82 Days

Hospital, institution, or street address where death occurred:
Vets. A.m. Hosp., Fort Howard, Maryland

How long in hospital or institution? 82 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 Harford Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-II

3.(a) FULL NAME: JAMES C. HUDGINS

3.(b) Social Security Number: 217-05-2129

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Eleanor Hudgins

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): 6-9-10

8. AGE: Years	Months	Days	If less than one day
37	5	0	...hrs. ...min.

9. Birthplace: Greenville, S. C.
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER
12. Name: Solomon Hudgins
13. Birthplace: Lawrence, S. C.

MOTHER
14. Maiden name: Hattie Jackson
15. Birthplace: Lawrence, S. C.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-13-47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Rayner Sanders
Address: 1412 E. Preston St., Balto., Md.

19. Nov 12, 1947 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9, 1947 at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19, 1947 to November 9, 1947 and that I last saw h.im alive on November 9, 1947

Immediate cause of death	DURATION
Carcinoma of the pleura, rt. with generalized metastases	Unknown
Due to:	
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M. D. CLIN. M. D. DIR. Other

Address V.A.H. FORT HOWARD, MD. Date signed 11-10-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09793

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1715 Spence Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3. (a) FULL NAME: FREDERICK W. IMFANG

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5/16/96

8. AGE: Years	Months	Days	If less than one day
51	6	9	hrs. min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)

10. Usual occupation: Steel Worker

11. Industry or business

FATHER

12. Name: Frederick Imfang

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden name: Mary Shraeder

15. Birthplace: Germany

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/29/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location: Rifle Hgts.

18. Funeral director: Edward Tomlinson

Address: 2359 Wash. Blvd.

19. Nov 28 1947 (Date rec'd by registrar) J.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26, 1947 at 7:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5, 1947 to November 26, 1947 and that I last saw him alive on November 26, 1947

Immediate cause of death	DURATION
Nephritis, interstitial, chr.	18 Mos. plus
Due to	
Due to	
(I) Hypertension arterial systemic (18 mos plus.)	
(2) Disease of the Heart, Class IV sec. to (I) (3) Ascites secondary to nephritis and Heart Disease.	

Other conditions (Include pregnancy within three months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Fleck

W.L. FLECK, M.D. ACT. CLIN. DIRECTOR

Address: V.A.H. FORT HOWARD, MD. Date signed: 11-26-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63a 09800

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk 22
(If outside city or town limits, write RURAL and give nearest town)
How long at above place of death? 27 yrs.
Hospital, institution, or street address where death occurred: Veterans Roseboro Rd.
How long in hospital or institution? 27 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: [illegible]
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mamie Jackson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Col	married

6.(b) Name of husband or wife: Daniel Foster Jackson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years	Months	Days	If less than one day
52			hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: Md

16. Informant: Danl F. Jackson (Husband)
Address: Abm

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6 1947 (month) (day) (year)
Cemetery or crematory: Mt Calvery Cems
Location: Baltimore Md
18. Funeral director: Elroy D. Wilson
Address: 1010 Brantley ave

19. Nov 4, 1947 (Date rec'd by registrar) A. L. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3 1947, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3 1947, to ——— 19..., and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Brain hemorrhage accident	Instantaneous
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other
Address: Dept. Met. Examiner Dundalk Md. Date signed 11/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09801

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Harford
City or town: Castleville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
Hood Convalescent Home
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore, 29
(If outside city or town limits, write RURAL and give nearest town)
Street No. Edmondson Ave & No. Bend Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ella Jarvis

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): unknown 1860

8. AGE: Years	Months	Days	If less than one day
87			____ hrs. ____ min.

9. Birthplace: Pennsylvania (Town, county and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: Charles Lind
13. Birthplace: ?

MOTHER
14. Maiden name: Mary ?
15. Birthplace: ?

16. Informant: Michael Lind
Address: 4005 S. Patterson Pk. Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-26-1947 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Edmondson Ave.

18. Funeral director: Lilly & Zeiler Inc.
Address: 403 S. Wolfe St.

19. 11/28/47 (Date rec'd by registrar) a. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9 1947 to Nov 24 1947 and that I last saw h... alive on Nov 23 1947

Immediate cause of death	DURATION
Chr. Myocarditis	2 wks
Due to: Generalized Arterio Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Entowitz M. D. or other
Address: Catonsville Date signed: 11/24

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 28 1947
BUREAU

COPY SENT TO CHO LOCAL REGISTRAR No. ..... DATE 17/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

09802

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Sweetair

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Sweetair

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joshua Jessop

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife Martha Jessop

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 11, 1860

8. AGE: Years	Months	Days	If less than one day
87	4	28	..... hrs. ..... min.

9. Birthplace Richmond, Va.

(Town, county, and state)

10. Usual occupation Wheelwright

11. Industry or business

FATHER

12. Name George W. Jessop

13. Birthplace Unknown

MOTHER

14. Maiden name Elizabeth Hale

15. Birthplace Maryland

16. Informant Myrtle A. Jessop

Address Sweetair, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-12-1947 (month) (day) (year)

Cemetery or crematory Chesnut Grove Cemetery

Location Sweetair, Md.

18. Funeral director A. R. Slade

Address 4907 York Rd. Balto., Md.

19. Nov 11 1947 A. W. Hedrick per Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1947 to Nov. 9, 1947 and that I last saw h.... alive on Nov. 9, 1947

Immediate cause of death	DURATION
Congestive Heart Failure	3 days.
Due to Arteriosclerotic Heart Disease	5 Mos.
Due to	
Other conditions Lobar Pneumonia	4 Days.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M.D.

M. D. or other

Address York Md. Date signed 11/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
NOV 11 1947
BUREAU OF

09803

83a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:

County: Baltimore

City or town: Monkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Monkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Corbett Rd
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Sarah Hannah Jones

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: James R. Jones

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64	11	0		

9. Birthplace: Endicott Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Taswell Atkins
13. Birthplace: Virginia

MOTHER
14. Maiden name: Francile Martin
15. Birthplace: Virginia

16. Informant: J. R. Jones
Address: Monkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4, 1947 (month) (day) (year)

Cemetery or crematory: Poplar Grove

Location: Cockeysville, Md.

18. Funeral director: Landon M. Bowles

Address: Sparks, Md

19. 11/2 (Date rec'd by registrar) 1947 Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1 1947, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to Nov. 1 1947

and that I last saw h er alive on Nov. 1 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	1 day
Due to	
Due to	
Other conditions: Arteriosclerosis Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. France M. D. or other

Address: Parkton, Md Date signed: 11/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
NOV 4 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09804

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The following space is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 401 N. Beechwood Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 N. Beechwood Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine Kahl

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	3	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name: — Hettiche

13. Birthplace: Md.

MOTHER

14. Maiden name: Louise Schmidt

15. Birthplace: Md

16. Informant: Miss Caroline Kahl

Address: 401 N. Beechwood Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-22-47 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Baltimore

18. Funeral director: George A. Farley

Address: Luther Ave + Fayette St.

19. ..... 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1944 to November 19 1947 and that I last saw h.. alive on November 19 1947

Immediate cause of death: Arteriosclerotic hypertensive Cardiac Disorder Disease — DURATION: 3 yrs

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eric A. Kahlmann M.D.

M. D. or other

Address: Ellicott City Md Date signed: 11/20/47

COPY SENT TO LOCAL REGISTRAR No. C.N.O. DATE 11/24/47

Birth + Death 09805

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF STILLBIRTH

K&C Reg. Dist. No.

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. **PLACE OF BIRTH:**
   County Baltimore
   City or town Essex
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: 7 Wilbur Rd
   Length of mother's stay in County 5 yrs
   (How many years, or months, or days. SPECIFY WHICH)

2. **USUAL RESIDENCE OF MOTHER:**
   State Md
   County Balto
   City or town Essex
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. 7 Wilbur Rd
   (If RURAL give LOCATION)

3. Name of child Baby Girl Kennedy
4. Date of birth Nov 16 1947 Hour 1 P M.
5. Sex F | 6. Twin or triplet
7. No. of weeks pregnancy 40

FATHER OF CHILD

8. Full name Jesse Estel Kennedy
9. Color W 10. Age at time of this birth 28 yrs.
11. Usual occupation machinist

MOTHER OF CHILD

12. Full maiden name Ruby Ellen McFarlin
13. Color W 14. Age at time of this birth 25 yrs.
15. Usual occupation Hw

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 4
    (b) How many other children were born alive but are now dead? None (c) How many other children were *born* dead? None

17. Did child die before labor? No During labor? yes
18. Pregnancy, complications of Hydramnios Rh —
19. Labor: (a) Complications of none
    (b) Induced?
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any
    (c) Did child die before operation? No
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes Monstrosity
    (b) Maternal causes Rh —

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature C M Baumgardner
    (Specify if M. D., midwife, or other)
    Address Balto 6 Md

23. (a) (Burial, cremation or removal) (b) Date thereof (month) (day) (year)
    (c) Cemetery or crematory
24. (a) Funeral director
    (b) Address

25. (a) (Date rec'd by registrar) (b) (Registrar)
26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

V. S. A10

* See Instruction C on stub.

NOV 20 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09806

129

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3104 Foster Ave., Balto. Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME

EDWARD J. KRASKI

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-24-15

8. AGE:

Years	Months	Days	If less than one day
32	7	9	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Die Setter

11. Industry or business

FATHER
12. Name: John Kraski
13. Birthplace: Poland

MOTHER
14. Maiden name: Elizabeth Kryger
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-7-47 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: Baltimore, Md.

18. Funeral director: John J. Duda

Address: 2829 Hudson St., Balto., Md.

19. 11/5/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1947 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 24 1947, to November 3 1947, and that I last saw him alive on November 3, 1947

Immediate cause of death	DURATION
Peritonitis, generalized, suppurative	One day plus
Due to: Perforation, ascending colon	"
Due to: Colitis, ulceration, cause unknown	Unknown
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
Address: V.A.H. FORT HOWARD, MD. Date signed: 11-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 L

09807

CERTIFICATE OF DEATH

Reg. Dist. No. 4 V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore - 19 -

City or town 2517 Sparrows Point Rd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Sparrows Point. Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2517 Sparrows Pt. Rd

(If rural, give LOCATION)

2.(a) If veteran, name war none.

3. (a) FULL NAME ROBERT FARRAR LEWIS. SR.

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married.

6.(b) Name of husband or wife Anna Mae Lewis 6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 4. 1889.

8. AGE:

Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace Philadelphia Pa. (Town, county, and state)

10. Usual occupation Manager owner.

11. Industry or business Tavern.

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Mrs. Anna Lewis

Address same #1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/6/47 (month) (day) (year)

Cemetery or crematory Meadow Ridge

Location Washington Blvd

18. Funeral director Sell & Geiler Inc

Address 403 S. Wolfe St.

19. 11-5 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3. 1947, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 43 1947, to Nov. 3 1947.

and that I last saw h. alive on Nov. 3. 1947.

Immediate cause of death	DURATION
Mitral Stenosis	4 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis N. Tollin M.D. M. D. or other

Address Sparrows Point Date signed 11/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09808

CERTIFICATE OF DEATH

Reg. Diat. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County 5501 Edmondson Ave
City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Hood Nursing Home
How long in hospital or institution? 4 Mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Aberdeen Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 149 Post Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Catherine Lumpkin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Edward T. Lumpkin
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 1861

8. AGE: Years	Months	Days	If less than one day
86	4	8	hrs. min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)
10. Usual occupation At home
11. Industry or business
FATHER 12. Name William Windsor
13. Birthplace Unknown
MOTHER 14. Maiden name Harriet Dutrow
15. Birthplace Unknown
16. Informant Harriet L. Davis
Address Aberdeen Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 14 1947 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore Md
18. Funeral director Harry P. Armacost
Address 4204 Ridgewood Ave
19. (Date rec'd by registrar) 19 J. C. Norman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1947, to Nov 11 1947; and that I last saw her alive on Nov 11 1947

Immediate cause of death	DURATION
Chr Myocarditis	1 Mon.
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Catonsville Md Date signed 11-12

Dr Howell 715 Fred'k B.c.

RECEIVED
NOV 15 1947
BUREAU V S

COPY SENT TO ~~LOCAL~~ C.N.O REGISTRAR No. _____ DATE 11/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09809

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH

County: Baltimore

City or town: Dundalk 22

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 19 Dundalk Ave

How long in hospital or institution? 67 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Same

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Thomas Lawrence Manning.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 4 1895

8. AGE:

Years	Months	Days	If less than one day
52	10	12	hrs. min.

9. Birthplace: Garrison Pk. Md. (Town, county, and state)

10. Usual occupation: Counter.

11. Industry or business: Bek Sleigh Co.

FATHER 12. Name: Thomas Manning.

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Martha J. Kelley.

MOTHER 15. Birthplace: Balto. Md.

16. Informant: Mrs Anna Stone (Sister)

Address: 84 Kinship Rd. Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1947 (month) (day) (year)

Cemetery or crematory: Oaklawn

Location: Eastern Ave.

18. Funeral director: Roland L. Fisher

Address: 2112 Dundalk Ave

19. 11/18/1947 (Date rec'd by registrar) A W Heldt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1947, at 9 am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16 1947, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlient	Instant.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. McSweeney M.D. (M. D. or other)

Address: Dundalk Md. Date signed 11/16/47

Deputy Medical Examiner

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09810

CERTIFICATE OF DEATH

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Balto.
City or town Dundalk 22
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: North Pt & Trappe Rds.
How long in hospital or institution? 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Manski. (MARY)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widow

6.(b) Name of husband or wife Joseph

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1874

8. AGE: Years	Months	Days	If less than one day
73	5	18	hrs. min.

9. Birthplace Baltimore.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Intermant Mary Barr
Address North Pt & Trappe Rd.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 12 3 47
(month) (day) (year)

Cemetery or crematory St Stanislaus
Location Balto Co

18. Funeral director J. J. Bruzdzenske
Address 1475 Eastern Ave R.D.

19. 12/1 1947 A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29/47, 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occident.	Immediate.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. McCarmine M.D.
Deputy Medical Examiner
Address Balto. Co. Dundalk, Md. Date signed 12/29/47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09811

42

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: BALTIMORE

City or town: LANSDOWNE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: **********

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: BALTIMORE

City or town: LANSDOWNE

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 141 ELIZABETH AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: WALTER E. MARINER

3.(b) Social Security Number: 220-12-6976

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife: SINGLE

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March. 19, 1886

8. AGE: Years	Months	Days	If less than one day
61	8	15	********** min.

8. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: Bar Tender

11. Industry or business: Frank E. She

FATHER 12. Name: Winifred Scott Mariner

13. Birthplace: Maryland

MOTHER 14. Maiden name: Kaziah Jennings

15. Birthplace: North Carolina

16. Informant: Mrs. Cora V. Condon

Address: 141 Elizabeth Ave. Lansdowne

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 7th. 47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Maryland

18. Funeral director: F.B. WIPPERT & SON

Address: 1300 EUTAW PLACE. 17

19. Nov 6 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 4 th. 19 47 at 10:45A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 28. 19 46 to Nov. 4 19 47

and that I last saw him alive on Nov 4 19 47

Immediate cause of death	DURATION
Arteriosclerotic Cardio - Vascular Disease	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Carl Rostley M. D. or other

Address: 1316 E Lombard St Date signed: 11/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10522

108

BC 44

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1116 Lexington Street
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME EDWARD MARSHALL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Estelle Marshall

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 4-4-94

8. AGE: Years	Months	Days	If less than one day
53	7	2	.....hrs. .....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Thomas Marshall

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Watkins

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 10 1947 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Katie Williams

Address 322 N. Schroeder St., Balto., Md.

19. 11/10 1947 (Date rec'd by registrar) C. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1947, 5:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5, 1947, to November 6, 1947 and that I last saw h.im alive on November 6, 1947

Immediate cause of death	DURATION
Lobar Pneumonia, right lower lobe	3 days plus
Due to Pneumococcus	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR. M.D. or other

Address V.A.H. FORT HOWARD, MD. Date signed 11-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

09812

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8 Leeway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Burl D. Mc Calmont

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Hazel E. Mc Calmont

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 13, 1913

8. AGE: Years: 34 Months: 1 Days: 20 If less than one day ..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual occupation: Electricians Helper

11. Industry or business: Bethlehem Steel Co.

FATHER

12. Name: Guy Mc Calmont

13. Birthplace: Pa.

MOTHER

14. Maiden name: Mary

15. Birthplace: Pa.

16. Informant: Hazel E. Mc Calmont

Address: 8 Leeway, Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1947 (month) (day) (year)

Cemetery or crematory: Moreland Memorial Park

Location: Taylor Ave.

18. Funeral director: Roland L. Fisher

Address: 211½ Dundalk Ave,

19. 11/6/47 19 ..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3rd. 1947, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
GUNSHOT (32 Cal.) Wound	
Thru' to Head	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 11/3/47

Where did injury occur? Dundalk (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Shot self 32 cal pistol Injured at work? No

23. SIGNATURE: M. D. Brown M.D.

Address: Dundalk, Md. Date signed 11/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Also correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

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BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09813

61

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
How long in hospital or institution? 15 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 720 Eastern Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3.(a) FULL NAME KYLIE McGALIN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Amelia McCalin
6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) April 29, 1891

8. AGE: Years	Months	Days	If less than one day
56	6	16	hrs. min.

9. Birthplace Floresville, Texas
(Town, county, and state)

10. Usual occupation Letter carrier

11. Industry or business

FATHER
12. Name William McGalin
13. Birthplace Texas

MOTHER
14. Maiden name Emma Black
15. Birthplace Texas

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 (month) 18 (day) 47 (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland
Howard N. Blight Jr.

18. Funeral director Blight Funeral Home
Address 4914 Belair Rd., Baltimore, Md.

19. 11/17 (Date rec'd by registrar) 19 47 A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 19 47, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 30, 1947, to November 15 1947 and that I last saw him alive on November 15, 1947

Immediate cause of death	DURATION
Cerebral embolus with infarction	5 days
Due to Endocardial thrombus	10 days
Due to Myocardial infarction	16 days
Other conditions Diabetes mellitus	5 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. Clinical Director
M. D. or other
Address VAH, Fort Howard, Md. Date signed

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

09814

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Balto. County

City or town: White Marsh.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Veterans Adm. Pulaski Hy near Campbells Branch Jct.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: White Marsh - Middle River P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt 14 - Box 22, Pulaski Hy.
(If rural, give LOCATION)

2.(a) If veteran, name war: U.S. Navy W.W. II

3.(a) FULL NAME William Horace Meidlein.

3.(b) Social Security Number 213-28-2605

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 28, 1924.

8. AGE: Years: 23 | Months: 8 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Aberdeen Md.
(Town, county, and state)

10. Usual occupation: Night watchman +

11. Industry or business: Maintenance helper Cement Block & Brick.

MOTHER FATHER

12. Name: Wm. Thomas Meidlein

13. Birthplace: Md.

14. Maiden name: Della Burkentine

15. Birthplace: Md.

16. Informant: Wm. Thomas Meidlein. Rt 22

Address: Middle River. Md Rt #14

17. burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26/47 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre de Grace, Md.

18. Funeral director: Lasch & Funeral Home.

Address: 7401 Belair Rd.

19. Nov 26 1947 (Date rec'd by registrar) John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1947, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 23 1947 to 19; and that I last saw h alive on 19

Immediate cause of death	DURATION
Gunshot wound of rt temple through skull.	Instantly
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 11/23/47

Where did injury occur: Pulaski Hy near Jct. Balto. Co. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Public Place

Means of injury: Gunshot wound Injured at work? Yes

23. SIGNATURE: J. McLearnon, M.D. Deputy Medical Examiner (Official or other)

Address: Balto. & Aberdeen Rds Md Date signed: 11-25-47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 09815

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH

County: Balto.

City or town: Sparrows Point.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 68" Mill - Bek Steel Co

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore 29.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 917 Woodington Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME August C. Meyer.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Ida V. Meyer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1896

8. AGE: Years: 51 | Months: 8 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business: Geo. Mitchell

FATHER — 12. Name: Charles Meyer

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Ida V. Meyer

Address: 917 Woodington Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 22nd. 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Maryland

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul Street, Baltimore

19. 11/20 19 47 A. W. Kedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 19 19 47 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 19 47 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	5 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Gearmine M.D. M.D. or other

Deputy Medical Examiner

Address: Dundalk, Md. Date signed: 11/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09816

47a BC

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 25 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1219 Rutland Avennue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Maxmillian Mielnick (Mielnik)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Anna Granville

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 15, 1893

8. AGE: Years	Months	Days	If less than one day
54	2	5	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Machine shop

FATHER
12. Name: Michael Mielnick
13. Birthplace: Poland

MOTHER
14. Maiden name: Anna Shminski
15. Birthplace: Poland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/24/47 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: 7225 Eastern Ave.

18. Funeral director: Clarence F. Hoffmann

Address: 1639 Broadway.

19. 11-26-47 (Date rec'd by registrar) R. W. Hadwick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 19 47, at 9:15 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26 19 47, to November 20 19 47 and that I last saw him alive on November 20 19 47

Immediate cause of death	DURATION
Carcinoma, laryngeal, with metastasis	6 months
Due to: Cachexia	4 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed 11-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61 09817

CERTIFICATE OF DEATH

Reg. Diat. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Balto. Co.

City or town Glenarm

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)

State Md. County Balto

City or town Glenarm

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna M. Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24-1874

8. AGE: Years	Months	Days	If less than one day
73	6		hrs. min.

9. Birthplace Minnesota (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace ?

MOTHER 14. Maiden name Unknown

15. Birthplace ?

16. Informant John F. Miller

Address Glenarm Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Wm. Gaugh Chapel

Location Greenwood Md.

18. Funeral director C. E. Arthur

Address Fork Md.

19. Nov. 17 1942 (Date rec'd by registrar) C. E. Arthur, D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1942, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 20 1941, to Nov 10 1942

and that I last saw her alive on Nov 10 1942

Immediate cause of death	DURATION
Diabetes mellitus	6 yrs
Due to Gangrene of foot	2 yrs
Due to Diabetic Coma	1 wk
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter M. Hammond M. D., or other

Address Baltimore Date signed 11-12-42

RECEIVED
NOV 17 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09818

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs 3
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 126 Forest Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Eva Carter Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Daniel B. Miller
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 4th 1874

8. AGE: Years	Months	Days	If less than one day
72	11	26	hrs. min.

9. Birthplace: Shirley Va
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:

FATHER
12. Name: Fitzhugh Carter
13. Birthplace: Va

MOTHER
14. Maiden name: Betty Pannell
15. Birthplace: Va.

16. Informant: Daniel Miller
Address: 28 Hopkins Place Balto Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Dec 3 1947
(month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto., Md.
18. Funeral director: Henry W. Jenkins & Son Co
Address: McCulloh & Orchard Sts

19. 12/2 1947 A.W. Hedrick Dpr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 30 1947, at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 19.. to Nov 30 1947
and that I last saw her alive on Nov 30 1947

	DURATION
Immediate cause of death: uremia	3 mon
Due to: Pyelonephritis	5 years
Due to:	
Other conditions: Chronic Valvular Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert B Taylor M. D. or other
Address: 104 W. Madison St Date signed: 12/2/47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

19813

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, Institution, or street address where death occurred:

Edmondson Ave. + Oakdale Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edmondson Ave + Oakdale Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: World War One

3.(a) FULL NAME Dr J. Carroll Monmonier - Monmonier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Mrs Helen F. Monmonier (Monmonnier)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22 1872

8. AGE: 75 Years | Months 9 | Days | If less than one day: hrs. min.

9. Birthplace: Derby ville Md (Town, county, and state)

10. Usual occupation: Physician

11. Industry or business

FATHER — 12. Name: J Carroll Monmonier Sr.

FATHER — 13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Sarah R Lawrenson

MOTHER — 15. Birthplace: Baltimore

16. Informant: Mrs J.C. Monmonier

Address: Edmondson Ave. + Oakdale

17. ~~Burial~~ (Burial, cremation, or removal. Which?) Date thereof Nov. 26/47. (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: 5501 Frederick Rd.

18. Funeral director: Harry H. Tuttle

Address: 4101 Edmondson ave

19. 11-24-1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22 1947, to date 19..... and that I last saw h... alive on several days ago 19.....

Immediate cause of death	DURATION
Arteriosclerosis Heart Disease	
Due to: Acute Heart Block	
Due to:	
Other conditions: Acute Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Alfred J. Gundry M.D. M. D. or other

Address: 6002 Frederick Rd Balto Date signed Nov 24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

10967

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or Institution? 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: West Halethorpe
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5737 - 1st Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-1

3.(a) FULL NAME: HENRY A. MULLER (ALSO KNOWN AS MILLER)

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie Muller

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): July 11, 1893

8. AGE: Years	Months	Days	If less than one day
54	3	27	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Meat clerk

11. Industry or business

FATHER
12. Name: Frederick Muller
13. Birthplace: Germany

MOTHER
14. Maiden name: Marguerite Ebert
15. Birthplace: Germany

16. Informant: Vets. Adm. Hosp. Clinical Records
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: 5501 Frederick Ave. Balto. Md.

18. Funeral director: Denny Funeral Home

Address: Light & Montgomery St. Balto Md.

19. 11/10/47 19..... A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1947 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1947 to November 8 1947 and that I last saw him alive on November 8, 1947

Immediate cause of death	DURATION
Carcinoma of left lung metastatic to mediastinal lymph nodes, brain and adrenals	3 mos plus
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: R. J. Cavalieri
R. J. CAVALIERI, M.D.
M. D. or other

Address: VAH Ft. Howard, Md. Date signed 11-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09820

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 117 Days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 117 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 746 Wasche Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: MURPHY, Willie A.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Grace Murphy

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): 2/22/97

8. AGE: Years	Months	Days	If less than one day
50	8	23	...hrs. ...min.

9. Birthplace: Dublin Co., North Carolina
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: Edward Murphy

13. Birthplace

MOTHER — 14. Maiden name: Martha Carol

15. Birthplace: North Carolina

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/19/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Charles R. Law

Address: 802 Madison Avenue, Baltimore, Md.

19. 11/17 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15, 19 47 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1947, to November 15 1947 and that I last saw him alive on November 15, 19 47

Immediate cause of death	DURATION
Tuberculosis, pulmonary, bilateral advanced with cavitation	4 mos.
Due to:	
Due to:	
Other conditions: Tuberculosis, intestinal moderate	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. N. KAGAN, M.D. M. D. or other

Address: VAH, Fort Howard, Md. Date signed: 11/15/47

VS A15 9-45.15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09821

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 100 S. Prospect Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 100 S. Prospect Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Washington H. Neily

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Grape

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 22, 1865

8. AGE: Years	Months	Days	If less than one day
81	11	5	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: J.W. Neily Co

FATHER — 12. Name: Joseph Wilson Neily

13. Birthplace: Maine

MOTHER — 14. Maiden name: Hannah Hands

15. Birthplace: Md.

16. Informant: Mr. Herbert H. Neily

Address: 412 Northway

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/29/47 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Greenmount Ave.

18. Funeral director: Wm. J. Tickner & Sons

Address: North & Pa. Aves.

19. 11/29 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27, 1947, at 9.30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 1947, to November 27 1947 and that I last saw h[illegible] alive on November 26 1947

Immediate cause of death	DURATION
Coronary Thrombosis	27da.
Due to Chr. Hypertensive Cardio-Vascular Disease	10 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward K. Gallagher M.D. M. D. or other

Address: Catonsville 28, Md. Date signed 11/28/47

VS A15 9-45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09822

932

CERTIFICATE OF DEATH

Reg. Dist. No. 4-1

1. PLACE OF DEATH:
County BALTIMORE
City or town ESSEX, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County BALTIMORE
City or town ESSEX
(If outside city or town limits, write RURAL and give nearest town)
Street No. 421 DORSEY AVENUE
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME KATHERINA MARGARET NEIMILLER

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife GEORGE LEONARD NEIMILLER
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) AUGUST 11, 1884

8. AGE: Years	Months	Days	If less than one day
63	2	22	..... hrs. ..... min.

9. Birthplace BA LTIMORE, MARYLAND
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business NONE

FATHER
12. Name August Krug
13. Birthplace Germany

MOTHER
14. Maiden name Hedrich Braunlig
15. Birthplace Germany

16. Informant George Leonard Neimiller
Address 421 Dorsey Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5 1947 (month) (day) (year)
Cemetery or crematory Maryland Memorial Park
Location Taylor Ave.
18. Funeral director John G. Connolly
Address 418 Eastern Ave. Essex

19. Nov. 3 - 1947 (Date rec'd by registrar) John G. Connolly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 2 1947 at 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1947 to November 1947 and that I last saw her alive on November 2 1947

Immediate cause of death	DURATION
Coronary Heart Disease, Acute Coronary Occlusion	
Due to Arterio-sclerotic Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph P. Crehan, M.D.
M. D. or other
Address Ridge Road, Balto 6 Date signed Nov 3, 47

3 homecopies

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09823

932

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Balto Co.

City or town: Rogers Forge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 Dunfarth Rd

Hospital, institution, or street address where death occurred: 3 days

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Hamilton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2901 Alvarado Square

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Annie B. Ott,

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Geo Ott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 5 ##

8. AGE:

Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace: Balto (Town, county, and state)

10. Usual occupation

11. Industry or business: At home

FATHER

12. Name: Michael Cole

13. Birthplace: Balto

MOTHER

14. Maiden name: Emma Burns

15. Birthplace: Balto

16. Informant: Walter Ott

Address: 603 Dorsey Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26 - 47 (month) (day) (year)

Cemetery or crematory: Mt Olivet Ea. Cemetery

Location: City

18. Funeral director: Hellrich Funeral Home

Address: 2108 Pleasant St

19. 11-25-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 ## 1947, at 9 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20, 1945 to Oct. 29, 1947

and that I last saw h. alive on Oct. 29, 1947.

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 hr.
Due to: Hypertensive CVD	3 yr.
Due to: ~~Diabetes Mellitus~~	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harold A. Grott, M.D. M. D. or other

Address: 8100 Harford Rd Date signed 11/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 BC 09824 30

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years, 6 months, 14 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 17 years, 6 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 733 West Lexington Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Laura Pear (Laura Max)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

6.(b) Name of husband or wife: John W. Pear

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1887

8. AGE: Years	Months	Days	If less than one day
60	5	4	hrs. min.

9. Birthplace: Martinsburg, West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Thomas Stevens

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Nancy Snyder

MOTHER — 15. Birthplace: West Virginia

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/21/47 (month) (day) (year)

Cemetery or crematory: Meadow Ridge Mem. Pk.

Location: Washington Blvd. (Dorsey no 9)

18. Funeral director: John J. Cowan & Son.

Address: 908-03 Hollins St.

19. 11-19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 1947, at 10:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1947 to November 18 1947 and that I last saw her alive on November 18 1947

	DURATION
Immediate cause of death: Chronic Sclerotic heart disease	5 yrs
Due to: Generalized arterio-sclerosis	"
Due to:	
Other conditions: Congestive heart failure	24 hrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 11-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 b BC 09825

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred:
V. A. H. Fort Howard, Md.

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2101 West North Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: NORMAN E. PIERCE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 14, 1897

8. AGE: Years	Months	Days	If less than one day
50	-	13	hrs. min.

9. Birthplace: Baltimore Co. Md.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Emanuel Pierce
13. Birthplace: Deceased

MOTHER
14. Maiden name: Alice Trippler Pierce
15. Birthplace: Deceased

16. Informant: Clinical Records
Address: Vets.Adm. Hosp., Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/ 1/ 47 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Wm. Tickner & Son
Address: North & Penna. Ave., Balto., Md.

19. 11/29 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27, 19 47 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 13, 19 47 to Nov. 27, 19 47 and that I last saw him alive on November 27, 19 47

Immediate cause of death	DURATION
TUBERCULOSIS, PULMONARY, ADVANCED, ACTIVE, BILATERAL.	2 yrs. +
Due to: Arteriosclerosis, generalized, cause unknown.	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George Leiner M.D. M. D. or other

Address: VAH, Fort Howard, Md. Date signed: 11/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 L

09826

Reg. Diat. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs.,2 mos.,11 days
Hospital, Institution, or street address where death occurred: Mt.Wilson Branch, Md.T.B.Sanatorium
How long in hospital or institution? 0 yrs.,2 mos.,11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles Co.
City or town LaPlata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
William Howard Posey

3. (b) Social Security Number
213-16-6060

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Evelyn Posey
6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) August 15, 1909

8. AGE:	Years	Months	Days	If less than one day
	38	2	29	hrs. min.

9. Birthplace LaPlata, Maryland (Town, county, and state)
10. Usual occupation Salesman
11. Industry or business

FATHER
12. Name F. Wills Posey
13. Birthplace Charles Co., Md.

MOTHER
14. Maiden name Mary D. Howard
15. Birthplace Charles Co., Md.

16. Informant William Howard Posey
Address LaPlata, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov.17, 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland, Maryland
18. Funeral director George L. Beyer, Jr.
Address 1512 Hollins St., Balto., Md.

19. Nov. 12, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1947 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2, 1947 to Nov. 13, 1947 and that I last saw him alive on November 13, 1947

Immediate cause of death	OURATION
Pulmonary Tuberculosis	10 yrs.
Due to Tubercle Bacilli	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Stewart S Shaffer M.D. M. D. or other
Address Mount Wilson, Md. Date signed 11/13/47

Is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 17 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83 b BC 09827

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Baltimore

City or town: Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, institution, or street address where death occurred:

Relay Sanitarium

How long in hospital or institution? 37 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4004 W. Rogers Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Katie Price

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles E. Price

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 16, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	28	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Stoll

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace:

16. Informant: Mrs E. K. Shipper, daughter

Address: 4004 W. Rogers Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/15/47 (month) (day) (year)

Cemetery or crematory: Baltimore Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 7-14 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1947, at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1947, to Nov 14 1947

and that I last saw h.. alive on Nov 14 1947

Immediate cause of death	DURATION
Cerebral thrombosis	6 days
Due to: Generalized arteriosclerosis	Long yrs
Due to:	
Other conditions: Left hemiplegia	6 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Louis P. Tuska M.D.

M. D. or other

Address: Relay 27, Md. Date signed Nov 17 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a BC 09828

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: —

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 714 N. Madeira St.

(If rural, give LOCATION)

2.(a) If veteran, name war: Unknown

3.(a) FULL NAME: Anton Prokorat

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown 1867

8. AGE: Years: 80 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: ~~Unknown~~ AUSTRIA (Town, county, and state)

10. Usual occupation: BAKER

11. Industry or business: Unknown

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Spring Grove State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26-47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Balto Md

18. Funeral director: Frank Gvach & Son

Address: 900 W. Chester St

19. 11/24 19 47 A.W. Retief Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23 1947 at 7:06A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1947 to Nov. 23 1947

and that I last saw h.s.m. alive on Nov. 23 1947

Immediate cause of death	DURATION
Cerebral Vascular	Approx.
Due to: Accident	2 wks.
Due to: Cerebral Arteriosclerosis	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. .....

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of .....

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Andrew Fuentes, M. D. M. D. or other

Address: Spring Grove State Hosp. Catonsville 28, Md. Date signed: 11-23-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09829

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 42

1. PLACE OF DEATH:

County: Baltimore

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs

Hospital, institution, or street address where death occurred:

1260 Stevens ave

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1260 Stevens ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Susan Dorothy Pryor

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wachter Dean Pryor

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Feb 18 1891

8. AGE:	Years	Months	Days	If less than one day
	56	9	6	...hrs. ...min.

9. Birthplace: Frostville, Fauty P.O. Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Home wife

FATHER — 12. Name: Alfred Pryor

13. Birthplace: Frederick Co. Md.

MOTHER — 14. Maiden name: ? Harman

15. Birthplace: Frederick, Md.

16. Informant: Mrs Eugene E. Pryor

Address: 1260 Stevens ave Arbutus 27 md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 29 Nov. 47 (month) (day) (year)

Cemetery or crematory: LOUDON PARK CEMETERY

Location: BALTIMORE MARYLAND

18. Funeral director: F.B.WIPPERT & SON

Address: 1300 EUTAW PLACE....17

19. Nov 28 19 47 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26 19 47 at 8 25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 47 to Nov 26 19 47 and that I last saw h... alive on Nov 26 19 47

Immediate cause of death	DURATION
(a) Apoplexy	1 da.
Due to (b) Arterial Hypertension	5 yrs
Due to (c) General arterio-sclerosis	15 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B.B. Brumbaugh M. D. or other

Address: 7609 Main St Elkridge Md Date signed: 11/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Skloven
7122 harford Road

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

09830

CERTIFICATE OF DEATH

Reg. Diat. No. 37

1. PLACE OF DEATH:
County: Parkville
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
2617 Windsor Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Parkville
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2617 Windsor Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mildred E. Punte

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Francis M. Punte, Jr.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 6th, 1916

8. AGE:	Years	Months	Days	If less than one day
	31	0	29	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: William Schoeberlein
13. Birthplace: Md.

MOTHER
14. Maiden name: Anna Wojciechoska
15. Birthplace: Poland

16. Informant: Mr. Francis M. Punte, Jr.
Address: 2617 Windsor Road, Parkville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-7-47 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Baltimore, Md.
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road, 14

19. 11/5 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4th, 1947, at 4.30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 1947, to Nov 4th 1947 and that I last saw h.e.r. alive on Nov. 3, 1947

Immediate cause of death	DURATION
Generalized carcinomatosis	3 months
Due to: Adeno-carcinoma of the breast	9 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged ststistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: P Skloven M. D. or other
Address: 7122 Harford Rd Date signed: Nov. 4. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C

C9831

Reg. Dist. No. 35

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Lancaster

City or town: Lancaster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 212 E. Orange St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Gilbert B. Rathfon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Mae Mervan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 22, 1874

8. AGE: Years	Months	Days	If less than one day
73	7	2	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER — 12. Name: Gilbert B. Rathfon

13. Birthplace: Lancaster, Pa.

MOTHER — 14. Maiden name: Pauline Kemp

15. Birthplace: Balto., Md.

16. Informant: Mrs. F. K. Seiner

Address: Lancaster, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27, 1947 (month), (day), (year)

Cemetery or crematory: Woodward Hill

Location: Lancaster Pa.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Nov. 27, 1947 (Date rec'd by registrar) Mrs. Edward S. Marbeine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 1947, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Crushed Chest	
Fractured Pelvis	
Due to internal injuries	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of Nov. 24, 1947

Where did injury occur? Parkton Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury automobile accident Injured at work?

23. SIGNATURE: J. M. France M. D., or other

Address: Parkton, Md. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
DEC 3 1947

09832

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

176

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore Co.

City or town Woodstock Manuta

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred:

Veteran am

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.

City or town Manuta Woodstock

(If outside city or town limits, write RURAL and give nearest town)

Street No. Veteran am

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Floyd Redmond

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8 1901

8. AGE: Years	Months	Days	If less than one day
46	3	23	..... hrs. ..... min.

9. Birthplace Howard Co Md.

(Town, county, and state)

10. Usual occupation Operator

11. Industry or business Lumber Mill

FATHER 12. Name James F. Redmond

13. Birthplace Maryland

MOTHER 14. Maiden name Ella N. Stocker

15. Birthplace Maryland

16. Informant Ella N. Redmond

Address Marriottsville Md

17. Burial Date thereof 11/4/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location Elliott City Md

18. Funeral director Chas. S. Mar Mahon

Address Catonsville Md

19. Nov 3 1947 Geo. McKeffer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947 at 9-20a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Hemorrhage from abdominal wound due to being struck by jaw of	
Due to Breaking saw Mill (machine)	
Other conditions accident	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Nov. 1. 47

Where did injury occur? Manuta (City or town) Baltimore (County) (State)

Injured at home, farm, industry, public place (where?) Industry

Means of injury Struck by jaw of saw mill Injured at work? Yes

23. SIGNATURE Geo. McKeffer Coroner

M. D. or other

Address 1010 Leadenhall Date signed Nov. 1 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 4 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138 BC 09833 44

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 31 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 633 W. Mulberry St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME
VICTOR RIKARD

3.(b) Social Security Number
Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	married

6.(b) Name of husband or wife: Alma Rikard 6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): October 3, 1910

8. AGE: Years	Months	Days	If less than one day
37	1	18	....hrs. ....min.

9. Birthplace: Newberry S.C.
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business

FATHER 12. Name: Backman Rikard

13. Birthplace: South Carolina

MOTHER 14. Maiden name: Carrie Bailey

15. Birthplace: South Carolina

16. Informant: Vets. Adm. Hosp. Clinical Records

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Lever Chapel Cemetery

Location: Prosperity, S.C.

18. Funeral director: Charles R. Law

Address: 802 Madison Ave. Balto, Md.

19. NOV 22 1947 (Date rec'd by registrar) Dawson L. Farbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1947 at 11:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1947, to Nov. 21 1947 and that I last saw h... in alive on November 21 1947

Immediate cause of death: Tuberculosis, pulmonary and Intestinal, chronic — DURATION: Unknown

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Substantiated as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H.V. BURNS, M.D. M. D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed: 11-23-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 25 1947
DEPARTMENT OF STATE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d

09834

Reg. Diat. No. 42

1. PLACE OF DEATH:

County Balto.

City or town Halethorpe (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 1250 Francis Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Balto.

City or town Halethorpe (If outside city or town limits, write RURAL and give nearest town)

Street No. 1250 Francis Ave. (If rurel, give LOCATION)

2.(a) If veleran, name war

3.(a) FULL NAME D. ZIMMERMAN RING, SR.

3.(b) Social Security Number 216-05-1697

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Violet E. Ring 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1890

8. AGE: Years	Months	Days	If less than one day
57	9	7	hrs. min.

9. Birthplace Relay, Md. (Town, county, and state)

10. Usual occupation Foreman

11. Industry or business Mutual Chemical Co.

FATHER 12. Name David Ring

13. Birthplace Relay, Md.

MOTHER 14. Maiden name Lydia Zimmerman

15. Birthplace Relay, Md.

16. Informant Mrs. Violet E. Ring

Address 1250 Francis Ave., Halethorpe

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/11/47 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 11/10 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1947, at 4.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.47, to Nov 7 1947 and that I last saw h... alive on Nov 6 1947

Immediate cause of death	DURATION
Carcinoma lung, right	7.
with pleural Effusion	2-4 mos.
Due to	
Due to	
Other conditions Sudden death - when sitting erect - probably acute cardiac failure (Include pregnancy within 3 months of death)	few minutes

Major findings of operations Date of op.

Autopsy results Biopsy Centrifuged pleural fluid = Carcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederic J. Baxter M. D. or other

Address 723 Mercantile Gtr. Bldg - Balto-N Date signed 11-9-47

MARGIN RESERVED FOR BINDING

Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 09835

CERTIFICATE OF DEATH

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto

City or town: 544 Pittsburg Ave, (If outside city or town limits, write RURAL and give nearest town)

Street No.: Dundalk R 2 mds (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Surname Boy

3.(b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced:

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 25-47

8. AGE: Years | Months | Days | If less than one day: 5 hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER 12. Name: John Ross

13. Birthplace: Maryland

MOTHER 14. Maiden name: Isabelle Henry

15. Birthplace: Maryland

16. Informant: John Ross (father)

Address: 544 Pittsburg Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 28 47 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem

Location: A. A. County Md

18. Funeral director: Mrs Rob't A. Edwards Dgt

Address: 1129 N. Carlisle St

19. 11-28 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1947, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 19 to November 25 19 47

and that I last saw him alive on November 25 19

Immediate cause of death: Premature — DURATION: Min.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. Thomas M. D. or other

Address: Dundalk Md Date signed 11-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09836

CERTIFICATE OF DEATH

Reg. Diat. No. KX

1. PLACE OF DEATH:
County: Baltimore
City or town: Jones Creek, Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideoce of mother)
State: Maryland County:
City or town: Jones Creek, Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2129 Alma avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GEORGE RUDIS

3.(b) Social Security Number: 213-09-0234

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Olga Rudis
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1897

8. AGE: Years	Months	Days	If less than one day
50	1	19	....hrs. ....min.

9. Birthplace: Greece
(Town, county, and state)

10. Usual occupation: Sparrows Point Tin Mills

11. Industry or business

FATHER
12. Name: Steve Georgaroadis
13. Birthplace: Greece

MOTHER
14. Maiden name: Thcano Sabou
15. Birthplace: Greece

16. Informant: Mr. John Papalas
Address: 2129 Alma ave. Sparrows Point Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/7/47 (month) (day) (year)

Cemetery or crematory: Greek Orthodox, Evangelismos

Location: Wisdom Mill Rd. Woodlawn

19. Funeral director: Jos. L. Agnew Funeral Home, Inc.

Address: 118 W. Mt. Royal Ave

11/5 - 47
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 19 47 at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h... alive on ....19....

Immediate cause of death: Coronary Occlusion

	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: ....M. D. or other
Address: Date signed 11/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

09837

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Bradshaw

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Bradshaw

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Camilla A. Ryan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas F. Ryan

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Dec 3, 1900

8. AGE: Years	Months	Days	If less than one day
46	11	—	..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William Amoss

13. Birthplace: Harford Co, Md

MOTHER — 14. Maiden name: Camilla Powers

15. Birthplace: Baltimore Md

16. Informant: Thomas F. Ryan

Address: Bradshaw Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 6, 1947 (month) (day) (year)

Cemetery or crematory: St. Stephens

Location: Bradshaw Md

18. Funeral director: Howard R. McLemore

Address: Aberdeen Md

19. Nov 4 1947 (Date rec'd by registrar) C. E. Authers Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3, 1947 at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31 1947 to Nov. 3 1947 and that I last saw h— alive on Nov. 2 1947

Immediate cause of death	DURATION
Congestive Heart Failure	4 days
Due to Carcinoma of breast with metastases to lungs, spine	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D. M. D. or other

Address: Bark Md. Date signed: 11/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
NOV 8 1967

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52a BC 09838 K

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5207 Wesley Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-1

3.(a) FULL NAME: CHARLES B. SCHULZE, JR.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Divorced

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: Div. years

7. Birth date of deceased (mo., day, yr.): July 20, 1891

8. AGE: Years	Months	Days	If less than one day
56	4	2	....hrs. ....min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER 12. Name: Charles Schulze

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Ida Haddas

MOTHER 15. Birthplace: Germany

16. Informant: Vets. Adm. Hosp. Clinical Records

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/25/47 (month) (day) (year)

Cemetery or crematory: Oaklawn Cemetery

Location: 7225 Eastern Ave. Balto. Md.

18. Funeral director: William Cook Inc.

Address: St. Paul and Preston Sts. Balto. Md.

19. 11-24-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 19 47 at 3:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 19 47, to Nov. 22 19 47 and that I last saw h... im ...alive on November 22 19 47

Immediate cause of death	DURATION
Hemorrhage from lung	sudden
Due to: Carcinoma of left kidney met-astatic to lung	unknown
Due to:	
Other conditions: Arteriosclerosis, generalized	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Substantiated as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. L. FLECK, M.D.
ACTING CLINICAL DIRECTOR
M. D. or other

Address: VAH FT. Howard, Md. Date signed: 11-22-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 09839

CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Balto.

City or town: Fullerton.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2yrs.

Hospital, institution, or street address where death occurred:

8719 Wendall ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Same

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Rudolph Schmeter.

3.(b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married ?

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 3rd 1884

8. AGE:

Years	Months	Days	If less than one day
63	11	28	hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Balto. Co. Police Reid

Address: Fullerton Police Station

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 4 47 (month) (day) (year)

Cemetery or crematory: Todds Almshouse

Location: Balto. Co. Md.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd.

19. Nov. 3, 1947 (Date rec'd by registrar) Mrs. G. L. Reynolds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1 1947, at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral accident.	Sudden
Due to: Acute asthenia	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. McCormick M.D. (M.D. or other)

Address: Deputy Medical Examiner Baltimore Md. Date signed 11/4/47


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NOV 7 1947
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d. 09840

CERTIFICATE OF DEATH

Reg. Diat. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Loch Raven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Chestnut Ridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Greenspring & Caves Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Aquilla Scott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 11, 1886

8. AGE: Years	Months	Days	If less than one day
61	5	6	..... hrs. ..... min.

9. Birthplace Balto.Co.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name George Scott
13. Birthplace Balto.Co.

MOTHER
14. Maiden name Rebecca Jones
15. Birthplace Balto.Co.

16. Informant John Scott
Address Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20, 1947 (month) (day) (year)
Cemetery or crematory Carrolls Chapel
Location Balto.Co.

18. Funeral director J.F.Eline & Sons
Address Reisterstown, Md.

19. Nov. 20 1947 (Date rec'd by registrar) Mary B. Eline. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1947, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Heart disease, complicated with	Sudden
Coronary occlusion	
Due to Heart disease, arterio-	1 yr
sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Bolling L. Anderson M.D. M. D. or other
Address Towson Md. Date signed 11/17/47

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NOV 21 1947

10519

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 36

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Providence Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MAGDALENE SIMMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles E. Simms

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 15th, 1865

8. AGE: Years	Months	Days	If less than one day
81	11	23	....hrs. ....min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business:

FATHER — 12. Name: Charles Chenowerth

13. Birthplace: England

MOTHER — 14. Maiden name: Anna Dall

15. Birthplace: Germany

16. Informant: Mr. Wm. Simms

Address: Providence Road

17. burial — Date thereof: 11/11/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Providence Methodist

Location: Towson, Md.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road

19. Nov 10 1947 — (Date rec'd by registrar) — Deputy Clerk — Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH: Nov. 8th 1947, at 10:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 1947 to Nov 7 1947 and that I last saw h[illegible] alive on Nov 7 1947.

	DURATION
Immediate cause of death: Apoplexy	5 days.
Due to: Arteriosclerosis & Hypertension	entr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other

Address: Towson-4-Md. Date signed: Nov 9 47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 94 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 94 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 916 N. Bond Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: CORNELIUS SLACUM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Married--Separated

6.(b) Name of husband/or wife: Bertha Slacum

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 12-31-86

8. AGE:

Years	Months	Days	If less than one day
60	10	23	...hrs. ...min.

9. Birthplace: Dorchester Co., Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Clinical Records, Vets. Adm. Hospital
Address: Fort Howard, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov 28, 1947
(month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Charles R. Law
Address: 802 Madison Ave., Baltimore, Md.

19. Nov 26, 1947
(Date rec'd by registrar)

A. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24, 1947 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22, 1947, to November 24, 1947 and that I last saw him alive on November 24, 1947

	DURATION
Immediate cause of death: Encephalomalacia	Unknown
Due to: Cerebral Arteriosclerosis	Unknown
Due to:	
Other conditions: Arteriosclerosis, generalized	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. C. N. Long & Snider
GEORGE E. SNIDER, M. D. M. D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed: 11-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09842

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Balto.
City or town: Mt. Wilson, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, Institution, or street address where death occurred:
Mt. Wilson, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Mt. Wilson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jerome L. Slaughter

3.(b) Social Security Number: P

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	married

6.(b) Name of husband or wife: Bertha E. Slaughter

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): January 11- 1886

8. AGE: Years: 61 | Months: 10 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Balto Md
(Town, county, and state)

10. Usual occupation: Coal

11. Industry or business: Mt Wilson Sanitarium

FATHER
12. Name: Jerome L. Slaughter, Sr.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Louisa Showacre
15. Birthplace: Baltimore, Md.

16. Informant: Bertha E. Slaughter
Address: Mt Wilson Md

17. Burial, cremation, or removal. Which? Burial Date thereof: Nov 25-1947
(month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto Md

18. Funeral director: Pfaff and B. M. Walters
Address: Pratt & Smiths Sts

19. 11-26-47 19 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 1947, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to Nov 22 1947
and that I last saw h... alive on Nov 22 1947

Immediate cause of death	DURATION
Coronary Occlusion	Instant
Hemorrhage.	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Nat. Date of
Where did injury occur? None, (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: None. Injured at work?

23. SIGNATURE: D. D. Caplea, M.D. Med. Exam. M. D. or other
Address: Reisterstown, Md. Date signed: 11-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09843

13/a

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Opitz Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 W. Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry B. Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Goldie B Smith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 19 1874

8. AGE: Years	Months	Days	If less than one day
73	1	12	..... hrs. ..... min.

9. Birthplace: Carroll Co.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER — 12. Name	Edward Smith
FATHER — 13. Birthplace	Carroll Co
MOTHER — 14. Maiden name	Adeline Barnes
MOTHER — 15. Birthplace	Carroll Co.

16. Informant: Goldie Bloom Smith
Address 34 W. Green St Westminster
1T. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 3 47 (month) (day) (year)
Cemetery or crematory: Pipe Creek
Location: Carroll Co.
1B. Funeral director: D. Bankard & Son
Address: Westminster Md.
19. 11/7/47 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1 19 47 at 3 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 19 47 to Nov 1 19 47
and that I last saw h... alive on Oct 21 19 47

Immediate cause of death	DURATION
Chr. Glomerular Nephritis	9 Mon
Due to: Arteriosclerosis	
Due to:	
Other conditions: Generalized Anasarca	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE: Irene Mowrer M. D. or other
Address: Catonsville Date signed 11-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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NOV 7 1967
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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932

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto Md
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8051 Chita Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Anna Matilda Stoecker

3. (b) Social Security Number: — —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Michael Stoecker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 18, 1881

8. AGE: Years 67 | Months 10 | Days 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: Geo Stoecker
13. Birthplace: Germany

MOTHER
14. Maiden name: Matilda — —
15. Birthplace: Germany

16. Informant: Mrs Madeline Wilson
Address: 8051 Chita Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22/47 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem
Location: Balto Md

18. Funeral director: Philip Herwig Sons
Address: 2024 Eutaw St

19. 11-20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 19 1947, at 2A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Nov 19 1947 and that I last saw h. alive on Nov 19 1947

Immediate cause of death	DURATION
Cerebral Apoplexy	Sudden
Due to: Arterio Sclerotic Cardio vascular Disease	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... injured at work?

23. SIGNATURE: Geo. M Baumgardner M. D. or other
Address: Balto 6 Md Date signed 11-19-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09845

932

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Shane, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Shane (P.O., White Hall, Md.)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Shane, Md. (P.O.- White Hall, Md.)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: CATHERINE VICTORIA TRAVERS ~~TRAVERS~~

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: -----
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5, 1861

8. AGE: Years	Months	Days	If less than one day
86	4	25	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Capt. Robert M. Travers
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Anna E. Meushaw
MOTHER 15. Birthplace: Balto., Md.
16. Informant: Mrs. Ruth M. Birmingham
Address: White Hall, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 2, 1947 (month) (day) (year)
Cemetery or ~~Crematory~~: Baltimore Cem.
Location: Baltimore, Md.
18. Funeral director: WM. J. TICKNER & SONS INC
Address: North & Pa. Aves, Balto., Md.
19. 12/2 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30 1947, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to Nov. 30 1947
and that I last saw h[illegible] alive on Nov. 30 1947

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: Arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. M. Frances M. D. or other
Address: Parkton, Md. Date signed: 11/30/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94 a 09846 32

Reg. Diat. No.

1. PLACE OF DEATH:
County: Balto.
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
503 Sudbrook Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 503 Sudbrook Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edith A. Travers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: John C. Travers
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 10, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	17	hrs. min.

9. Birthplace: Relay, Md.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: United Service Organization

FATHER
12. Name: Henry Bottomer
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Ward
15. Birthplace: England

16. Informant: Mrs. Hershel L. Irish
Address: 503 Sudbrook Rd. 8

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/20/47 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 11-19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 17 19 47 at 8:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/26 19 44 to 11/17 19 47
and that I last saw h. alive on 11/17/47 19

Immediate cause of death	DURATION
Coronary Thrombosis	10 min.
Due to: Coronary Sclerosis	6 mons.
Due to: Art. Sclerosis	1-2 years
Due to:	
Other conditions: Hypertension	1-2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James A. Miller Jr. M. D. or other
Address: Pikesville 8, Md. Date signed: 11/18/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

09847

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore

City or town Texas
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yr. 8 mo. 29 da

Hospital, Institution, or street address where death occurred:
Baltimore County Home

How long in hospital or institution? 13 yr. 8 mo. 29 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Hamilton
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME James Trimble

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	

6.(b) Name of husband or wife Mrs Sarah Lee Trimble

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1852

8. AGE: Years	Months	Days	If less than one day
95	0	9	..... hrs. ..... min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation Manufacturer of office machinery

11. Industry or business

FATHER
12. Name William Trimble
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Shannon
15. Birthplace Ireland

16. Informant Baltimore County Home Register
Address Texas. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 28 1947 (month) (day) (year)

Cemetery or crematory Baltimore County Home Cem.

Location Texas Md.

18. Funeral director Landon-M. Brooks

Address Sparks. Md.

19. Nov 27 (Date rec'd by registrar) 1947 Wm J. Lahiland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947, at 11 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/29 1934, to 11/27 1947.

and that I last saw him alive on 11/26/ 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Holmes C. Emmons M.D.
M. D. or other

Address Catonsville Md. Date signed 11/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 4 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1630

09848

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH:

County: Balto.

City or town: Parkeley 6 Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years.

Hospital, Institution, or street address where death occurred:

108 Cheseley ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Couoty:

City or town: Same

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME William Wallring.

3.(b) Social Security Number 212-01-6216

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 6/1878.

8. AGE:

Years	Months	Days	If less than one day
69	1	25.	hrs. min.

9. Birthplace: Germany. (Town, county, and state)

10. Usual occupation: Engineer.

11. Industry or business: Retired.

FATHER — 12. Name: William Wallring.

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Gretchen

MOTHER — 15. Birthplace: Germany

16. Informant: William W. Wallring.

Address: 108 Cheseley ave

17. Burial (Burial, cremation, or removal, which?) Date thereof: Mr. 4-1947 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore, Md.

18. Funeral director: Lesach Funeral Home

Address: 7401 Belair Rd.

19. Mar. 3- 19 47 (Date rec'd by registrar) Mrs. A. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1 1947, at 4 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1947, to Nov 1 1947

and that I last saw h alive on 19

Immediate cause of death	DURATION
Overcome by Gas.	Immediate
Due to: Monoxide Poisoning (Gas Stove in room)	
Due to: Carcinoma left Jaw.	1½ yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Nov 1 1947

Where did injury occur? Parkeley (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?) At Home -

Means of Injury: Gas poison Injured at work? No

23. SIGNATURE: J. M. Lawrence M. D.

Deputy Medical Examiner

Address: Glenelg Md Date signed: 11/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


NOV 7 1907

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

99 BC 09844

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 95 days
Hospital, Institution, or street address where death occurred:
Vets.Adm.Hospital, Fort Howard, Maryland
How long in hospital or institution? 95 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3912 Belair Road
(If rural, give LOCATION)
2.(a) If veteran, name war: (Army) (Retired)

3.(a) FULL NAME: JOHN H. WALSH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Widower
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-1-68

8. AGE: Years	Months	Days	If less than one day
79	6	1	hrs. min.

9. Birthplace: England (Town, county, and state)
10. Usual occupation: Army, Retired
11. Industry or business:

FATHER
12. Name: Henry Walsh
13. Birthplace: England

MOTHER
14. Maiden name: Mary Dunner
15. Birthplace: Ireland

16. Informant: Clinical Records, Vet.Adm. Hospital
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 5 47 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland
18. Funeral director: Harold Blight Funeral Home
Address: 4814 Belair Road Baltimore, Maryland

19. Nov. 4 1947 (Date rec'd by registrar) F. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2nd 1947 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30th 1947 to November 2nd 1947 and that I last saw him alive on November 2nd 1947

Immediate cause of death	DURATION
Aspiration pneumonia,	duration Unknown
Due to	
Due to	
Other conditions: Empyema, encapsulated, chr.	Unknown
rt., Arteriosclerosis, generalized	Unknown

(Include pregnancy within three months of death)

Major findings of operations: Amputation left leg. for gangrene of left foot, secondary to thrombosis of left femoral artery. Date of op. 9-19-47

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
Address: V.A.H. FORT HOWARD, MD. Date signed: 11-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 b

09850

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Approximately 16 Hrs.

Hospital, institution, or street address where death occurred: Vets. Adm. Hospital, Fort Howard, Maryland

How long in hospital or institution? Approximately 16 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 916 S. Clinton Street (If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3. (a) FULL NAME: ALFRED WARDELL

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of ~~husband or~~ wife: Katherine Wardell

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 5-12-94

8. AGE: Years: 53 Months: 6 Days: 2 If less than one day: ... hrs. ... min.

9. Birthplace: Louisville, Kentucky (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER

12. Name: Morris Wardell

13. Birthplace: Unknown

MOTHER

14. Maiden name: Mary Lambert

15. Birthplace: Loraine, Ohio

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/17/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Clarence F. Hoffman Funeral Home

Address: 1639 N. Broadway, Baltimore, Md.

19. 11/17 1947 (Date rec'd by registrar) A. W. Hedrick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14, 1947, at 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13, 1947, to November 14, 1947, and that I last saw him alive on November 14, 1947

Immediate cause of death: Tuberculosis, pulmonary, active, far advanced with cavitation — DURATION: 30 Yrs.

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): (1) Tuberculosis, intestinal mild (2) Laceration & Ulceration superficial, left frontal area.

Major findings of operations:

Date of op.:

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W M Carmine M.D.

W.M. CARMINE, M.D. DEPUTY MEDICAL EXAMINER

Address: DUNDALK, 22, MARYLAND Date signed: 11-14-47

10505

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hours

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford County

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1718 Green Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Roy J. Warden

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	white	?

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 21, 1905

8. AGE:

Years	Months	Days	If less than one day
42	4	14	..... hrs. ..... min.

9. Birthplace: Kokoma, Indiana
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business: ?

FATHER
12. Name: ? Warden
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-7-48 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 1/10 (Date rec'd by registrar) 1948 a. W. Hedrich per T Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1947 at 9:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Pneumonia, lobar	24 hours
Due to: Fracture of right leg, lower	7 weeks
Due to:	
Other conditions: Fresh fracture of skull	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above (gw)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 9-13-47

Where did injury occur? Route 22 Churchville Harford Co. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Public highway

Means of injury: Struck by automobile Injured at work? no

23. SIGNATURE: Geo. T. McKieffer Evan J. Bell, M. D. or other

Address: 1010 Sedgeman Date signed: Nov. 6, 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Md. State Police Dept. returned statistical form for Motor Vehicle acc. stating that Dr. Maldeis' office were classifying death as due to a natural cause. According to Census Bureau the M. V. takes precedence.

ams. 1-26-48

AGE: Letter from Dr. Zimmerman filmed g113 11-24 1947: LL

State of Maryland 940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 09851

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7707 Chestnut Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7707 Chestnut Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton W. Watkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-03-8935

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mamie Watkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1884 1885

8. AGE: Years	Months	Days	If less than one day
62	0	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business Peteman & Brown

FATHER
12. Name Samuel R. Watkins
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Annabell Caskey
15. Birthplace Baltimore, Maryland

16 (a) Informant Mamie Watkins
(b) Address 7707 Chestnut Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/15/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1317 St. Paul Street

19 (a) NOV 14 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1947, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 19.. to Nov 12 1947, and that I last saw h.. alive on Nov 12 1947.

Immediate cause of death Coronary Thrombosis — Duration ½ hour

Due to Arteria Sclerosis — 5 yrs

Due to Hypertension Heart Disease — 3 yrs

Other Conditions Gray Graine — 2 yrs

Duodenal Ulcer
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed L. Zimmerman M. D.
Address 9858 Reisterstown Rd Date signed 11/13/47

VS 150

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 b pr 09852

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Int. Pleasant.
How long in hospital or institution? 3½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2592 Druid Park Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: David Weber.

3.(b) Social Security Number: 212-07-2668

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Belle Weber
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE:

Years	Months	Days	If less than one day
59	7	10	hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Upholsterer
11. Industry or business
FATHER 12. Name: Jacob Weber
13. Birthplace: Russia
MOTHER 14. Maiden name: Pearl Kimirovsky
15. Birthplace: Russia
16. Informant: Guy Weber (son)
Address: 2592 Druid Park Drive
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-30-47 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: Jack Lewis Inc
Address: 2100 Eutaw Place
19. 12/2 (Date rec'd by registrar) 1947 A.W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1947 at 5 57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1947 to Nov. 28, 1947 and that I last saw him alive on Nov. 28, 1947

Immediate cause of death	DURATION
Myocardial failure	
Due to: Coronary Occlusion	Sudden
Due to: Diabetes mellitus	12 yrs
Other conditions: Pulmonary Tuberculosis	4 months

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. Gudmen M.D.
M. D. or other
Address: Reisterstown Md Date signed 12/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
DEC 2 1947
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09853

940

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH

County: Baltimore

City or town: Sparrows Point 19

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

6701 North Pt. Rd.

How long in hospital or institution? 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6701 North Point Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Henry Weir.

3.(b) Social Security Number 213-07-4541

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Blanche S.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8/1881

8. AGE: Years	Months	Days	If less than one day
66	6	22	..... hrs. ..... min.

9. Birthplace: Pa. Manchester. (Town, county, and state)

10. Usual occupation: Retired (Clerical)

11. Industry or business: Bethl. Steel Co.

FATHER 12. Name: John Oliver Weir.

13. Birthplace: Pa.

MOTHER 14. Maiden name: Amanda Auchenbach.

15. Birthplace: Pa.

16. Informant: Roland Fetzer Weir (Son)

Address: 7207 Fairview Ave. Balto 27 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/1/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. 11/29 1947 (Date filed by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 27 1947 at 9 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 27 19 47 to ..... 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary Occlusion X	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: J. McCormick M.D. Deputy Medical Examiner M.D. or other

Address: Balto Co. Dundalk Md. Date signed 11/27/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 44

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bethlehem Steel Co.
(c) Hospital or institution; Sparrows Point, Balto., Co.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 09854
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3321 Foster Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERBERT C. WESTERFIELD

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-7827

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lillian B. Westerfield
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 12, 1891

8. AGE: Years	Months	Days	If less than one day
56	5	18	hr. min.

9. Birthplace Staten Island, N.Y. (Town, county, and state)
10. Usual Occupation Riveter
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name ? Westerfield
13. Birthplace N.Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace N.Y.

16 (a) Informant Lillian B. Westerfield
(b) Address 3321 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-47. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location 7225 Eastern Av. Rd. Ba. Co.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 (a) Nov 11 1947 (Date rec'd by registrar) (b) R. W. Aldrich per F Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1947, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D. Medical Examiner.
Date signed 11/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

09855

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address (where death occurred)
404 E Penn. Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 404 E Penn. Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rachel Williams

3.(b) Social Security Number

4. Sex: F.
5. Color or race: C
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Alexander
6.(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): Nov. 22nd 1881
8. AGE: Years: 66 Months: Days: If less than one day: hrs. min.
9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John H. Brown
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Madline V. Burke
15. Birthplace: Balto Co. Md.

16. Informant: Alexander Williams
Address: 404 E. Penn. Ave Towson Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3rd 1947 (month) (day) (year)
Cemetery or crematory: Pleasant Rest
Location: Towson Balto. Co. Md.

18. Funeral director: Bafrow Mamus & Wright
Address: 721 Aisquith St Balto 2 Md.

19. 12-3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to Nov. 30 1947
and that I last saw h alive on Nov. 30 1947

	DURATION
Immediate cause of death: Cardiac Renal Disease	
Due to:	1y 6 mo
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irvin A Johnson M.D.
M. D. or other
Address: 2329 Guilford Ave Date signed: Dec. 5 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46d

09856

Reg. Dist. No. 30

1. PLACE OF DEATH:
County ~~Calvert~~ Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Calvert
City or town Solomons
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Benjamin Woodburn

3. (b) Social Security Number ?

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	W

8.(b) Name of husband or wife Ellen Woodburn
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1866

8. AGE:

Years	Months	Days	If less than one day
81	8	21	..... hrs. ..... min.

9. Birthplace St. Marys Co. Md.
(Town, county, and state)
10. Usual occupation Waterman
11. Industry or business

MOTHER FATHER
12. Name ? Woodburn
13. Birthplace Md
14. Maiden name Matilda ?
15. Birthplace Md

16. Informant Alma Dixon
Address 801 N. Linwood Ave., Balto., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1947 (month) (day) (year)
Cemetery or crematory Solomons
Location Solomons, Md
18. Funeral director A. A. Harkness & Son
Address Mutual, Md
19. 11/19/47 (Date rec'd by registrar) A. W. Hedrick Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 1 1947, to Nov 17 1947
and that I last saw h... alive on Nov 17 1947

Immediate cause of death	DURATION
Carcinoma of Rectum	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE George Dr Howard M. D. or other
Address Solomons Md Date signed 11/17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct data is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
NOV 19 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09857

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 04

MD

1. PLACE OF DEATH:
County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
2856 Dodge Farm Rd.
How long in hospital or institution? all life.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2856 Dodge Farm Rd
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Edward J Woolfrey. WOOLFREY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 11th 1944

8. AGE: Years 3. Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Balto Co Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Edward J. Woolfrey Sr
13. Birthplace Va

MOTHER
14. Maiden name Dorothy Dellone
15. Birthplace Balto Co Md

16. Informant Mr. Ed. J. Woolfrey Sr
Address 2856 Dodge Forest Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-26-47 (month) (day) (year)
Cemetery or crematory Ebenezer
Location Chase Md

18. Funeral director John G. Connelly
Address 428 Eastern Ave

19. Nov 26 19 47 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 19 47 at 9 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fracture base skull	Immediate
Due to Auto accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, ~~or homicide~~ Accident Date of 11/23/47
Where did injury occur? Sparrows Pt. Balto. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Run over by Auto Injured at work? At home.

23. SIGNATURE D M Learning M.D.
Address Balto Co Md Date signed 11/23/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The former age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 8 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09858

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 22 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 5 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ormsby M. Zealor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Della Zimmerman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 14, 1870

8. AGE: Years	Months	Days	If less than one day
77	1	3	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER — 12. Name: ? John Zealor

FATHER — 13. Birthplace: ? Pa

MOTHER — 14. Maiden name: Elizabeth ? Smith

MOTHER — 15. Birthplace: ? Pa

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-20-47 (month) (day) (year)

Cemetery or crematory: Williams Waters Memorial

Location: Cooptatown Md

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd Balto 6 Md

19. 11/20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17 1947 at 12:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1947 to November 17 1947 and that I last saw him alive on November 17 1947

Immediate cause of death	DURATION
Cerebral hemorrhage, right frontal	8 hrs.
Due to: Cerebral arteriosclerosis	indefinite
Due to: Generalized arteriosclerosis	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 11-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
NOV 21 1947
BUREAU

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address 2615 Hillcrest Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) ~~City or town~~ Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Hillcrest Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maymie E. Zirkle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Carl H. Zirkle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1895

8. AGE: Years	Months	Days	If less than one day
52	0	24	hr. min.

9. Birthplace Riverside, Virginia
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Samuel D. Lawhorn
13. Birthplace Virginia

MOTHER
14. Maiden Name Froney Whiteside
15. Birthplace Virginia

16 (a) Informant Mr. Carl H. Zirkle
(b) Address 2615 Hillcrest Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-47 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk.
Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) NOV 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st, 1947, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945, to Nov 1 1947, and that I last saw her alive on Oct 31 1947.

	Duration
Immediate cause of death Cardiac decompensation (rt. ventricular failure)	
Due to Massive pleural effusion	
Due to Cancer of Pleura metastasized from Cancer of Breast.	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation March 1945
Major findings of operation: Cancer of breast.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Road Date signed 11-1-47

VS 150

VS A15 9-45-15M